



*Department of Health and Mental Hygiene*

## **Mental Hygiene Administration**

# ***IMPLEMENTATION REPORT OF THE FY 2013 ANNUAL STATE MENTAL HEALTH PLAN***

***A CONSUMER – ORIENTED SYSTEM***

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“The services and facilities of the Maryland Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, sex, or national origin and applies to the provisions of employment and granting of advantages, privileges, and accommodations.”

“The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits, and employment opportunities.”

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# ACKNOWLEDGEMENTS

## The FY 2013 State Mental Health Plan

**A**s in the past, the FY 2013 State Mental Health Plan is the result of the hard work of many people, particularly the Mental Hygiene Administration (MHA) staff, consumers, providers, mental health advocacy groups, the Planning Committee of the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council and representatives of the Core Service Agencies. However, during the past three years the participation in the development of this annual plan was much increased through additional organizational and community stakeholders who gave their time to review and offer input into the FY 2013 Plan through all day Mental Health Plan Development Meetings held in the spring. This year, on April 27, 2012 the gathering included representatives of:

*Consumer, child and family advocacy organizations*

*Wellness and Recovery Centers*

*Mental health providers and provider organizations*

*Local Mental Health Advisory Committees*

*Maryland Association of Core Service Agencies*

*Core Service Agencies' Boards of Directors*

*Protection and Advocacy Agencies*

*The Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council*

*Maryland Blueprint Committee*

*The Traumatic Brain Injury Advisory Board*

*Alcohol and Drug Abuse Administration (ADAA) and other Maryland DHMH state agencies*

*Other interested stakeholders and citizens of Maryland*

The use of break-out groups, as well as the availability of and interaction among key MHA staff and stakeholders, allowed much to be accomplished in a limited period of time. The workgroups focused on the Department of Health and Mental Hygiene (DHMH) Seven Principles of Behavioral Health Integration and identified recommendations to support planning efforts in developing a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues. While not all suggestions/recommendations were able to be included in the final document many of the concepts prioritized by the break-out groups are expressed, at least in part, in a number of strategies. The input of the participants, through the group discussions and interactive process, has been invaluable. We at MHA thank all of you who contributed to the development of this plan and look forward to continued collaboration as we proceed with our goals and future endeavors in a behavioral health system of care.

# **STATE OF MARYLAND MENTAL HYGIENE ADMINISTRATION**

## **MISSION**

The Department of Health and Mental Hygiene's Office of Behavioral Health and Disabilities will develop an integrated process for planning, policy, and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions and developmental disabilities. The Mental Hygiene Administration will, through publicly funded services and supports, promote recovery, resiliency, and health for individuals who have emotional or psychiatric disorders.

## **THE VISION**

*The Vision of our behavioral health system of care is drawn from fundamental core commitments:*

- Coordinated, quality system of care that is supportive of individual rights and preferences
- Availability of a full range of services
- Seamless linkages to services for the consumer delivered through a system of integrated care
- Recognition that co-occurring conditions are common
- Focus on treatment, behavioral health, support, recovery, and resilience
- Services developed in collaboration with culturally competent stakeholders in an environment that is culturally sensitive
- Improved health, wellness, and quality of life for consumers across the life span

## **VALUES**

*The values underpinning this system are:*

### **(1) SUPPORTIVE OF HUMAN RIGHTS**

Persons with psychiatric disabilities have the same rights and obligations as other citizens of the state. Consumers have the right to choice, to retain the fullest possible control over their own lives, and to have opportunities to be involved in their communities.

### **(2) RESPONSIVE SYSTEM**

The behavioral health system of care must be responsive to the people it serves, coherently organized, and accessible to those individuals needing mental health care. Information must be readily available for individuals to enter and proceed through the system in a more appropriate and timely manner. The hospitals are one part of the community-based mental health system. The behavioral health system of care must collaborate with other public and private human health service systems in order to allow for continuity of care and facilitate support with all activities of life.

### **(3) EMPOWERMENT**

Consumers, families, and advocates will be involved in decision-making processes, individually at the treatment level and collectively in the planning and operational aspects of the mental health system. An array of services and programs must be available to allow for consumer choice in obtaining and using necessary services. Relevant programs and services that recognize varying cultural, ethnic, and racial needs are imperative.

- (4) ***COMMUNITY EDUCATION***  
Promote wellness through early identification and prevention activities for risk groups of all ages. Public education and efforts that support families and communities must be incorporated into our service system. Increased acceptance and support for mental health services come from increased awareness and understanding of psychiatric disorders and treatment options.
- (5) ***FAMILY AND COMMUNITY SUPPORT***  
We must provide families with the assistance they need in order to maintain or enhance the support they give to their family members. We will strive to provide services to persons within their communities with the availability of natural/family supports.
- (6) ***LEAST RESTRICTIVE SETTING***  
An array of services will be available throughout the state to meet a variety of consumer needs. These services should be provided in the least restrictive, most normative, and most appropriate setting.
- (7) ***WORKING COLLABORATIVELY***  
Collaborations with other agencies at the state and local level will be fostered so support to consumers is inclusive of all activities of life. This will promote a consistently appropriate level of mental health services.
- (8) ***EFFECTIVE MANAGEMENT AND ACCOUNTABILITY***  
Accountability is essential to consistently provide an adequate level of mental health services. Essential management functions include monitoring and self-evaluation, rapid response to identified weaknesses in the system, adaptation to changing needs, and improved technology. We must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.
- (9) ***LOCAL GOVERNANCE***  
Local management of resources, resulting from the implementation of Core Service Agencies, will improve continuity of care, provide needed services in a timelier manner, improve the congruence of services and resources with needs, and increase economic efficiency due to the closer proximity of the service delivery level.
- (10) ***STAFF RESOURCES***  
The presence of a competent and committed staff is essential for the provision of an acceptable level of mental health services. Staff must be provided with adequate support systems and incentives to enable them to focus their efforts on the individuals who receive care from them. Opportunities must be provided for skill enhancement training or retraining as changes in the service system take place.

## **List of Acronyms**

<b>ACA</b>	Affordable Care Act
<b>ACT</b>	Assertive Community Treatment
<b>ADAA</b>	Alcohol and Drug Abuse Administration
<b>ASO</b>	Administrative Services Organization-ValueOptions®Maryland
<b>BHI</b>	Behavioral Health Integration
<b>BHSIC</b>	Behavioral Health Systems Improvement Collaborative
<b>BRSS TACS</b>	Bringing Recovery Supports to Scale Technical Assistance Center Strategy
<b>BIP</b>	Balancing Incentive Program
<b>CBH</b>	Community Behavioral Health Association of Maryland
<b>CCAC</b>	Cultural and Linguistic Competence Advisory Committee
<b>CEO</b>	Chief Executive Officer
<b>CEU</b>	Continuing Education Units
<b>CHIPRA</b>	Children’s Health Insurance Program Reauthorization Act
<b>CILS</b>	Centers for Independent Living
<b>CLCTI</b>	Cultural and Linguistic Competence Training Initiative
<b>CME</b>	Care Management Entity
<b>CMS</b>	Center for Medicare/Medicaid Services
<b>COD</b>	Co-Occurring Disorders
<b>CSA</b>	Core Service Agency
<b>CQT</b>	Consumer Quality Team
<b>DDA</b>	Developmental Disabilities Administration
<b>DDC</b>	Dual Diagnosis Capability
<b>DHCD</b>	Maryland Department of Housing and Community Development

<b>DHMH</b>	Maryland Department of Health and Mental Hygiene
<b>DHR</b>	Maryland Department of Human Resources
<b>DJS</b>	Maryland Department of Juvenile Services
<b>DORS</b>	Division of Rehabilitation Services
<b>DPSCS</b>	Department of Public Safety and Correctional Services
<b>DSS</b>	Department of Social Services
<b>EB-SE</b>	Evidence-Based Supported Employment
<b>EBP</b>	Evidence-Based Practice
<b>FLI</b>	Family Leadership Institute
<b>GOC</b>	Governor's Office for Children
<b>HUD</b>	Housing and Urban Development
<b>IFSC</b>	Interagency Forensic Services Committee
<b>IIMR</b>	Integrated Illness Management and Recovery
<b>IRMA</b>	Information Resource Management Administration
<b>IT</b>	Information Technology
<b>LAA</b>	Local Addictions Authority
<b>LEAP</b>	Leadership Empowerment and Advocacy Project
<b>LMHAC</b>	Local Mental Health Advisory Committee
<b>LGBTQ</b>	Lesbian, gay, bi-sexual, transgender, questioning
<b>LMB</b>	Local Management Board
<b>MA</b>	Medical Assistance or Medicaid
<b>MACSA</b>	Maryland Association of Core Service Agencies
<b>MAP</b>	Maryland Access Point
<b>MARFY</b>	Maryland Association of Resources for Families and Youth
<b>MCCJTP</b>	Maryland Community Criminal Justice Treatment Program

<b>MCF</b>	Maryland Coalition of Families for Children’s Mental Health
<b>MCO</b>	Managed Care Organization
<b>MDLC</b>	Maryland Disability Law Center
<b>MDoA</b>	Maryland Department of Aging
<b>MDOD</b>	Maryland Department of Disabilities
<b>MFP</b>	Money Follows the Person
<b>MHA</b>	Mental Hygiene Administration
<b>MHAMD</b>	Mental Health Association of Maryland, Inc.
<b>MHBG</b>	Federal Mental Health Block Grant
<b>MHCJP</b>	Mental Health & Criminal Justice Partnership
<b>MMHEN</b>	Maryland Mental Health Employment Network
<b>MHFA</b>	Mental Health First Aid
<b>MIS</b>	Management Information Systems
<b>MOU</b>	Memorandum of Understanding
<b>MPAH</b>	Maryland Partnership for Affordable Housing
<b>MSDE</b>	Maryland State Department of Education
<b>NAMI MD</b>	National Alliance on Mental Illness-Maryland
<b>NOC</b>	Network of Care
<b>NOFA</b>	Notice of Funds Availability
<b>ODHH</b>	Governor’s Office of the Deaf and Hard of Hearing
<b>OFS</b>	Office of Forensic Services
<b>OHCQ</b>	Office of Health Care Quality
<b>OMS</b>	Outcome Measurement System
<b>OOOMD</b>	On Our Own of Maryland, Inc.
<b>PATH</b>	Projects for Assistance in Transition from Homelessness



<b>PCCP</b>	Person Centered Care Planning
<b>PERS</b>	Peer Employment Resource Specialist
<b>PHA</b>	Local Public Housing Authorities
<b>PMHS</b>	Public Mental Health System
<b>PRA</b>	Project-Based Rental Assistance
<b>PRP</b>	Psychiatric Rehabilitation Program
<b>PRTF</b>	Psychiatric Residential Treatment Facility
<b>QuIP</b>	Quality Incentive program
<b>RRP</b>	Residential Rehabilitation Program
<b>RTC</b>	Residential Treatment Center
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SDC</b>	Self-Directed Care
<b>SE</b>	Supported Employment
<b>SEFEL</b>	Social and Emotional Foundations for Early Learning
<b>SED</b>	Serious Emotional Disorders
<b>SMI</b>	Serious Mental Illness
<b>SOAR</b>	Supplemental/Social Security, Outreach, Access, and Recovery
<b>SPA</b>	state plan amendment
<b>SPMI</b>	Serious and Persistent Mental Illness
<b>SSA</b>	Social Security Administration
<b>SSDI</b>	Social Security Disability Insurance
<b>SSI</b>	Supplemental Security Income
<b>SUD</b>	Substance Use Disorder
<b>TAC</b>	Technical Assistance Collaborative, Inc.
<b>TAMAR</b>	Trauma, Addiction, Mental Health, and Recovery

<b>TAY</b>	Transition-Age Youth
<b>TBI</b>	Traumatic Brain Injury
<b>UMD EBPC</b>	University of Maryland Evidence-Based Practice Center
<b>UMD SEC</b>	University of Maryland Systems Evaluation Center
<b>UMBC</b>	University of Maryland – Baltimore County
<b>VO</b>	Value Options®Maryland
<b>WRAP</b>	Wellness Recovery Action Plan
<b>WRC</b>	Wellness and Recovery Center

## SYSTEM GOALS TABLE OF CONTENTS

Many of the MHA goals, objectives, and strategies in this State Mental Health Plan for children, adolescents, and adults are a result of existing interagency cooperation as well as public and private partnerships that focus on the coordination of care and improvement of service systems particularly in the areas of: public education; awareness; training of consumer, families, and mental health professionals; promotion of wellness, prevention, and diversion activities; enhanced efforts in evidence-based and promising practices; cultural competency as well as support of employment, self-directed care, and affordable housing options. MHA strategies continue to involve effective and efficient collaborations to support sustainability of transformation gains that promote recovery and resiliency.

To continue improvement in the delivery of prevention, treatment and recovery support services and to focus the Administration's efforts toward promoting expansion of behavioral health, MHA has continued to organize its FY 2013 plan activities based on the Substance Abuse and Mental Health Services Administration (SAMHSA's) Eight Strategic Initiatives (Listed in the Appendix).

Now, in FY 2013, MHA is participating in Maryland's behavioral health integration to improve and impact care across behavioral health and somatic domains. In the days to come, MHA and ADAA, under the leadership of DHMH, will work together with consumers, families, providers, advocacy organizations, professionals, and interested citizens to complete this process as MHA and ADAA move together toward a financing and integration model that will continue to promote high-quality, consumer-centered, behavioral health care.

	PAGE
GOAL I: Increase Public Awareness and Support for Improved Health and Wellness.....	9
GOAL II: Promote a System of Integrated Care Where Prevention of Substance Abuse and Mental Illness is Common Practice Across the Life Span.....	29
GOAL III: Work Collaboratively to Reduce the Impact of Violence and Trauma for Individuals with Serious Mental Illness and Other Special Needs.....	48
GOAL IV: Provide a Coordinated Approach to Increase Employment and Promote Integration of Services and Training to Develop and Sustain an Effective Behavioral Health Workforce.....	65
GOAL V: Build Partnerships to Increase the Provision of Affordable Housing and Reduce Barriers to Access in Order to Prevent Homelessness for Individuals with Mental Illness.....	78
GOAL VI: Utilize Data and Health Information Technology to Evaluate, Monitor, and Improve Quality of Behavioral Health System of Care Services and Outcomes.....	89
APPENDIX .....	108

## **GOAL I. INCREASE PUBLIC AWARENESS AND SUPPORT FOR IMPROVED HEALTH AND WELLNESS.**

**Objective 1.1. The Mental Hygiene Administration (MHA), in collaboration with the Core Service Agencies (CSAs), will continue to work with the behavioral health community to initiate educational activities and disseminate, to the general public, current information related to psychiatric disorders, prevention mechanisms, treatment services, and supports.**

(1-1A)

*\*Federal Mental Health Block Grant*

MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Missouri Department of Health, and the National Council for Community Behavioral Health, will continue implementation of the Mental Health First Aid-USA (MHFA USA) initiative for adults and youth in Maryland and throughout the United States.

Indicators:

- Continued publication, distribution, and promotion of Mental Health First Aid Participant Manual, Teaching Notes, and other materials
- Work continued with Mental Health Association of Maryland, Inc. (MHAMD), national partners, and advocates to finalize a MHFA USA Youth Manual and teaching notes
- Curriculum supplements piloted for law enforcement and higher education; research and development initiated for workplace, veterans, faith communities, and older adults modules
- Number of people trained
- Continued partnership with MHAMD and Core Service Agency (CSAs) to deliver additional training to local communities such as Area Offices on Aging, Department of Social Services, law enforcement, parole and probation, judges, public health, emergency medical services personnel, shelter workers, higher education, and state employees
- Program sustained through course fees and other funding sources

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; Cynthia Petion and Carole Frank, MHA Office of Planning and Training; DHMH; CSAs; Mental Health Association of Maryland (MHAMD); Maryland Coalition of Families for Children's Mental Health (MCF); On Our Own of Maryland (OOOMD); Missouri Department of Mental Health; the National Council for Community Behavioral Health; Mental Health and Criminal Justice Partnership (MHCJP); Maryland Police and Correctional Training Commission; other behavioral health advocacy groups

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The Mental Health First Aid (MHFA) Program is a collaborative implementation through three national partners: Maryland Department of Health and Mental Hygiene (DHMH), Missouri Department of Mental Health, and the National Council for Community Behavioral Health. MHFA, an eight hour course that teaches lay people methods of assisting someone who may be in the early stages of developing a mental health problem or in a mental health crisis situation, continued to expand in FY 2013. Maryland has been instrumental in adapting the MHFA curriculum for American audiences (the original MHFA program was developed in Australia) and setting the instructor standards to ensure educational fidelity to the program. Maryland's efforts are led by the Mental Health Association of Maryland (MHAMD) charged with producing and distributing the materials nationally as well as managing the training program in Maryland.

Since its inception more than 5,300 Maryland residents have been certified to provide MHFA. In FY 2013, 78 MHFA trainings were conducted, certifying more than 1,300 Marylanders. In addition, more than 120 instructors are now certified in Maryland. Since the official launch of the program in late 2009, almost 113,000 participant manuals and over 2,300 instructor kits have been distributed nationally. During the FY 2013, the MHAMD added closed captioning in English and Spanish to the DVDs included in the teaching kits to help ensure accessibility.

A comprehensive Youth Mental Health First Aid program, for adults who work with youth, was launched in-state in FY 2013 and was offered in early FY 2014. MHAMD and the national partners have worked collaboratively in the development of the Youth Mental Health First Aid teaching kit and participant manual. The transition to an 8 hour core curriculum was piloted and prepared in FY 2013, with a national roll-out at the Mental Health First Aid Instructor Summit in April 2013. Full transition to the 8-hour program should be complete by December 2013. The Maryland team has been key in the creation and testing of both the new eight-hour curriculum and the Youth curriculum. In addition, three curriculum supplements, which adapt the core adult program for specific venues, were developed and piloted for workplace, law enforcement, and higher education. The groups that have participated in MHFA trainings include: consumers and family members; criminal justice staff; administrative law judges; human resources professionals; Core Service Agencies (CSAs); primary health and behavioral health organizations; corporations; and students, faculty, and staff at a number of colleges and universities across the state.

MHFA has been established in multiple police and corrections training academies, in the state Department of Juvenile Services, and in an expanded number of programs on college campuses across the state. Mental Health First Aid has also proven to serve as a valuable cross-training program as mental health and substance use treatment integrates in the state of Maryland. Several CSAs have trained staff in the core program as well as instructors. The program helps clarify the language, the approach, and the messages across agencies. In addition, navigators who will be helping people through the processes associated with the implementation of healthcare reform are being certified in MHFA to improve their ability to better communicate with individuals experiencing a mental health problem or crisis and better assist them in selecting and accessing programs, services, and care plans.

Maryland's leadership has resulted in a number of accomplishments and expressions of interest in MHFA from a number of other states. During FY 2013, MHFA, which was recently added to the Federal Registry of Evidence-based Practice Programs, received attention nationally. The President of the United States highlighted the program in post Sandy Hook related remarks. A Bipartisan Coalition of State Senators introduced a MHFA bill in Connecticut in January 2013 and legislators in Arizona pushed to have MHFA placed in the state budget in April 2013. In Maryland, Mental Health First Aid was included in the Mental Health and Substance Use Disorder Safety Net Act of 2013 (SB 822/HB 1245). MHFA has been featured in magazine articles and media broadcast venues across the nation.

It is expected that trainings in Maryland will continue beyond FY 2013, sustained through course fees, sales of manuals, and grants. Data is collected by MHAMD and the program is tracked on StateStat.

**Strategy Accomplishment:**

This strategy was achieved.

(1-1B)

MHA, in collaboration with the Core Service Agencies (CSAs), will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.

Indicators: Continued support for:

- Maryland Coalition of Families for Children's Mental Health's (MCF) and Mental Health Association of Maryland's (MHAMD's) Children's Mental Health Awareness Campaign – "Children's Mental Health Matters"; number of public service announcements aired, volume of literature disseminated, and other outreach activities implemented
- National Alliance on Mental Illness (NAMI MD) – NAMI WALK, Family to Family, and other education programs
- On Our Own Maryland, Inc. (OOOMD) – Anti-Stigma Project workshops
- Network of Care – promotion and usage
- MHAMD – outreach campaign for older adults
- CSA – outreach/media campaigns
- Wellness and Recovery Centers – outreach efforts

Involved Parties: Cynthia Petion and Robin Poponne, MHA Office of Planning and Training; Al Zachik, MHA Office of Child and Adolescent Services; Steve Reeder, MHA Office of Adult Services; MHA Office of Forensic Services; MHA Office of Consumer Affairs; appropriate MHA staff; CSAs; MCF; MHAMD; NAMI MD; OOOMD; Wellness and Recovery Centers (WRC); community providers

MHA Monitor: Robin Poponne, MHA Office of Planning and Training

## **FY 2013 activities and status as of 6/30/2013 (end-year report):**

### **Children's Mental Health Matters**

This year MCF and MHAMD continued the partnership to promote the successfully received *Children's Mental Health Matters* awareness campaign. This social marketing effort is designed to build a network of information and support for families across Maryland and raise awareness of children's mental health. The two organizations have initiated a "Call to Action" to all stakeholders, requesting their participation in and support of this project. In 2013, more than 100 professional associations, advocacy organizations and provider associations signed on as Campaign partners. The new School Champion Initiative was launched with 69 Maryland schools, many of them from Baltimore City Public Schools, participating in at least one awareness raising event during Awareness Week (May 5-11, 2013). By establishing partnerships with stakeholders and other concerned organizations, recognition of Children's Mental Health Awareness Week has been increased and enhanced.

Campaign awareness kits, including green awareness bracelets, posters, window clings, and brochures, were distributed to more than 540 partners and other supporters in advance of Awareness Week. Several events were held throughout the state, including a youth panel on navigating young adulthood with mental health challenges attended by 200 people, a poster reception to honor the student poster artist attended by First Lady Katie O'Malley, and a flash mob at the Inner Harbor. In addition to traditional print and broadcast media, social media tools such as the Web site, Google Calendar, and Facebook page were used to disseminate information. The Web site also features resources such as Webinars, fact sheets about children's mental health, and guidance on how to get help. The campaign continued its partnership with local broadcast affiliates, radio and television. Public service announcements (PSAs) were once again aired in FY 2013 resulting in 1.1 million impressions. News programs, including a live call-in segment during the evening news hour reached more than 217,000 viewers, and over 1 million fans were reached with Campaign-related postings on several of our media partners' Facebook pages. The campaign's Web site is [www.childrensmentalhealth.org](http://www.childrensmentalhealth.org).

### **NAMIWALKS**

MHA works with the National Alliance on Mental Illness-Maryland (NAMI MD) and other stakeholders to support NAMIWALKS, a kick-off event for successfully promoting *MAY MENTAL HEALTH MONTH*. Representatives from MHA attended meetings and advance events to promote and launch NAMIWALKS. In 2013, NAMIWALKS took place on May 18<sup>th</sup> at Rash Field, Baltimore Inner Harbor. There was only one event in one location this year. However, food vendors were on site as a convenience to the participants. Estimated attendees for the Walk numbered 2,000.

The awareness walks are designed to highlight the importance of education, advocacy, and support for persons diagnosed with a serious mental illness and their families. This annual event also helps reduce stigma often associated with mental illness by providing an opportunity for positive interactions and networking. The NAMI MD peer and family support education programs offer unique, experiential learning programs for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. In FY 2013, 527 participants completed the Family-to-Family Education Programs. The Peer-to-Peer participants numbered 173 and NAMI Basics, a free, six-session program designed for parents and other family caregivers of children and adolescents with emotional and behavioral difficulties, had 52 participants in FY 2013.

### **The Anti-Stigma Project**

On Our Own of Maryland, Inc. (OOOMD) and MHA continue to collaborate efforts to fight stigma within the mental health system through the Anti-Stigma Project (ASP). In FY 2013, the ASP presented 52 workshops throughout the state, which trained 1,014 people in the full program and reached a wide audience, at least 267 of the participants, through tangentially related organizations which included: colleges/universities, a forensic hospital, a halfway home, a program for individuals with developmental disabilities, a senior service center, and a hospital for veterans. ASP workshops may be designed and tailored to address specific populations and situations. A workshop on internalized stigma, *An Inside Look at Stigma*, continues to be well received and a workshop on creating non-stigmatizing environments is in process for FY 2014. ASP formed committees in FY 2013 to explore condensing one of its most requested Workshops - *Stigma in Our Work and in Our Lives*, from its current three hour length to a one-hour presentation to increase its availability to the public. This interactive presentation is designed to reduce stigmatizing behaviors, attitudes, and practices within the mental health and addiction recovery communities.

### **Network of Care**

The Maryland Network of Care (NOC) for Behavioral Health continues to enhance Maryland residents' ability to access consumer-driven, recovery-oriented and community-specific information regarding available mental health services in all of Maryland's 24 jurisdictions. Specialized service information is provided for Maryland's Youth, as well as a special portal for Veterans and families to help service men and women returning from Iraq and Afghanistan with behavioral issues, to obtain access to services. Core Service Agencies (CSAs) have been encouraged to support, at the county level, the expansion and promotion efforts of Network of Care. The use of NOC is encouraged and fostered in the Wellness and Recovery Centers, as well as other community settings, and plans are underway to train peer support specialists and peer educators to be able to train consumers on the use of NOC. Many consumers have received on-site training in the utilization of personal health record features and in the use of individual advance directives.

In FY 2013, the Maryland Network of Care for Behavioral Health recorded 2,327,670 sessions. The NOC veterans' portal recorded over 233,272 during the same time period. ([www.maryland.networkofcare.org](http://www.maryland.networkofcare.org)).



### **Outreach Campaign for Older Adults**

Through the Mental Health Association of Maryland's (MHAMD) "Coalition on Mental Health and Aging," the state level staff of MHA, Maryland Department of Human Resources (DHR), Maryland Department of Aging (MDoA) work hand-in-hand with the Coalition membership to jointly plan opportunities, cross-trainings, client sharing responsibilities, and opportunities for additional partnerships. *Mental Health in Later Life: a Guidebook for Older Marylanders and the People Who Care for Them* was produced and distributed by the MHAMD to bring education and resources regarding important issues of mental health and aging to older Marylanders, caregivers, and helping professionals. The Portable Document Format (PDF) version of the guidebook is available on MHAMD's mental health and aging Web site at [www.mdaging.org](http://www.mdaging.org).

Several Core Service Agencies (CSAs) also provide training, outreach, and consultation to various community settings with older adult involvement. As appropriate, MHAMD folds Mental Health Advance Directive education into programs and trainings to both providers and consumers.

### **Core Service Agencies**

Core Service Agencies (CSAs) also report outreach and media campaigns through the CSA Plans, Annual Reports and the Maryland Association of Core Service Agencies' (MACSA's) Annual reports. Among the FY 2013 outreach activities were included: trainings for providers, physicians, and community members on new practices such as trauma-informed care, Mental Health First Aid, and availability of community resources; behavioral health presentations; town hall meetings on behavioral health services; and outreach supports and services to older adults, transition-age youth, veterans, and homeless individuals. The CSAs, overall, average more than 300 sponsored trainings and public education events each year.

### **Wellness and Recovery Centers**

Throughout Maryland there are approximately 28 Wellness & Recovery Centers (WRCs) that are established as places of ongoing peer support and training opportunities. Of these, 26 are affiliated with MHA's Office of Consumer Affairs. There is an increased focus on the involvement of the WRCs in surrounding community organizations and activities to allow the centers and their members to become active participants in the greater community. In some jurisdictions, progress has been made within local MHA-funded WRCs to utilize staff and blended funding resources, in collaboration with the Alcohol and Drug Abuse Administration's (ADAA's) Local Addictions Authorities (LAAs), to serve consumers with behavioral health issues. In FY 2013, each of the 26 WRCs provided four education forums internally and six outreach sessions on mental health topics to consumers in hospitals, outpatient mental health clinics, and other sites that provide mental health services. Additionally, at least four sessions were dedicated to educating the community at large with the goal of reducing stigma and each WRC conducted a minimum of 12 activities (speakers, presentations), designed to promote wellness and recovery. The WRCs also produced newsletters and/or calendars containing announcements and/or write-ups of the special events.

### **Strategy Accomplishment:**

This strategy was achieved.

(1-1C)

Continue efforts to enhance communication and education through use of social media tools and networks.

Indicators:

- Social media outlets, such as Facebook or Twitter, utilized to promote public mental health awareness and improved communication among MHA, CSAs, providers, advocates, consumers, and family members
- At a minimum, throughout the fiscal year, 15 micro-blogs pertaining to mental health efforts and information produced
- Promotion of MHA Twitter account @DHMH\_MHA and percentage of “followers” increased by 15% within the year.
- Continued exploration of appropriate social media outlets to bolster Child and Adolescent initiatives and/or to provide Peer-to-Peer support

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems (MIS) and Data Analysis

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA, through DHMH departmental-wide efforts, established social media outlets through Facebook and Twitter as a means of disseminating mental health data and news among MHA, CSAs, providers, advocates, consumers, family members, and the public at large.

In FY 2013, MHA’s Twitter account, @DHMH\_MHA, posted 75 tweets or micro-blogs pertaining to mental health information and issues on the local and national level. The account currently is “following” 91 other Twitter accounts relating to governmental, public health and mental health issues. The account is being “followed” by almost 353 other accounts all which are programmed to disseminate the information tweeted to their resources.

Both social media sites disseminate information provided by the DHMH Secretary, staff, and other stakeholders that are involved with the administration. Monthly data, regarding the increase in the number of followers to the @DHMH\_MHA account, are submitted via StateStats. As new technology emerges, MHA will continue to explore appropriate social media outlets to bolster child and adolescent initiatives and that are geared more towards a “tween or teen” population.

**Strategy Accomplishment:**

This strategy was achieved.

(1-1D)

MHA, in collaboration with the Core Service Agencies (CSAs) will continue to facilitate an all-hazards approach to emergency preparedness and response for MHA as an Administration and for the mental health community at large.

Indicators:

- All-Hazards Disaster Mental Health Plans from the CSAs updated
- Multi-state Consortium and Brain Tree Solution utilized as resources

Involved Parties: Marian Bland, MHA Office of Special Needs Populations; Gail Wowk, DHMH Emergency Management; Facilities CEOs; Facilities Emergency Managers; CSAs; Office of Preparedness and Response (OP&R); OHCQ; Local Boards; Consultants (Braintree)

MHA Monitor: Marian Bland, MHA Office of Special Needs Populations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA's Office of Special Needs Populations reviews, facilitates updates to, and assists in the revision of, the All-Hazards Mental Health Disaster Plans for MHA and all the CSAs. CSA All-Hazards Plans are partially updated in selected areas of the plan as CSAs are in the process of revisiting and redrafting the total plan for FY 2014. Statewide, emergency contact information is in place and CSA contact lists were updated and distributed to appropriate individuals. Also, in FY 2013, a "Needs Request" grid was developed to inform each local health department of issues that must be resolved with their assistance during disaster related incidents.

Monitoring progress has been challenging due to staff shortages. However, MHA incident command structure has been updated and behavioral health staff have been included in trainings as evidenced by increased State Emergency Operations Center (SEOC) attendance at sessions. Communication has been enhanced by the sharing of regular Situation Reports (SIT REP).

MHA was actively involved in the behavioral health response during Hurricane Sandy and providing technical assistance to CSAs with addressing the community mental health needs at shelters. MHA continues to participate in Emergency Management Meetings at the Office of Preparedness and Response (OP&R) as well as scheduled training exercises.

Additionally, MHA has been working with the Federal Emergency Management Agency (FEMA) Region III Disaster Behavioral Health Coordinators and Braintree Solutions Consulting, Inc. to examine the newly developed disaster behavioral mental health operational plan template created for the Region III states and the best practices disaster behavioral mental health training curriculum.

MHA, in collaboration with the CSAs, will continue to facilitate an all-hazards approach to emergency preparedness and response for MHA as an Administration and for the mental health community at large.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 1.2. MHA will continue efforts that facilitate recovery, build resiliency, and develop mechanisms to promote health and wellness across the lifespan.**

(1-2A)

*\*Federal Mental Health Block Grant*

MHA, in collaboration with On Our Own of Maryland (OOOMD), will continue to support statewide activities promoting the continuance of Wellness Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement.

**Indicators:**

- Two facilitator follow-up trainings held
- Continued WRAP training for the deaf and/or hard of hearing community consumers
- Continued implementation of WRAP training in local consumer peer support and advocacy organizations across Maryland such as Wellness and Recovery Centers (WRC)
- WRAP training facilitated to ADA Peer Recovery Support Specialists
- Continued training of Olmstead Peer Support Specialists as an additional WRAP resource for hospital discharge planning

**Involved Parties:** Susan Kadis, MHA Office of Consumer Affairs; Marian Bland, MHA Office of Special Needs Populations; OOOMD; CSAs; WRCs

**MHA Monitor:** MHA Office of Consumer Affairs

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA, in collaboration with On Our Own of Maryland (OOOMD), continues statewide delivery of Wellness and Recovery Action Plan (WRAP) training in efforts to enhance wellness and recovery, and incorporate WRAP as a resource within community mental health programs. WRAP trainings have been instituted in the peer specialists training module and is incorporated into all consumer-run Wellness and Recovery Centers as a model for peer support. Spring Grove Hospital Center and Sheppard Pratt Hospital have each hired peer specialists, all with WRAP facilitator training. More than 2,730 people have participated in the WRAP orientation. In FY 2013, three follow-up facilitator trainings were held in November attended by 32 facilitators. Maryland now has more than 139 WRAP facilitators trained in a five-year period.

On March 26-28, an Introduction to Mental Health Recovery, including WRAP training was provided for individuals who are deaf and hard of hearing. Attendees numbered 30. Also, the WRAP Outreach project received a grant from the Krieger Fund for \$12,500 to hold sessions in the greater Baltimore area in FY 2013. WRAP will be represented at the *Bringing Recovery Supports to Scale Technical Assistance Center Strategy* (BRSS TACS) Policy Academy in FY 2014 to discuss efforts to bring certified peer specialist credentialing for mental health and substance use to Maryland as well as plan WRAP training for Peer Recovery Support Specialists.

**Strategy Accomplishment:**

This strategy was achieved.

(1-2B)

*\*Federal Mental Health Block Grant*

Collaborate with the MDQuit Center of the University of Maryland – Baltimore County (UMBC), consumers, providers, private partnerships, and other behavioral health stakeholders to promote and implement smoking cessation initiatives for all individuals served by the behavioral health system of care to reduce early mortality rates.

Indicators:

- Utilization of results of Substance Abuse and Mental Health Services Administration (SAMHSA) Policy Academy for Maryland on Wellness and Smoking Cessation to develop and implement Statewide Plan in conjunction with the Alcohol and Drug Abuse Administration (ADAA), providers, CSAs, and consumers
- Guidance and technical assistance provided to CSAs on successful smoking cessation initiatives (such as two models implemented at Silver Spring Wellness and Recovery Center and at Lower Shore Friends, Inc.)
- Increased awareness, promotion of public education, and raised consciousness of the essential role of smoking cessation in overall wellness through multiple media sources, as well as shared information gained through the state's Outcome Measurement System (OMS) survey
- Smoking cessation resources added to Network of Care (NOC)
- Collaboration with the MDQuit Center in the development of tools for ongoing evaluation of the effectiveness of smoking cessation efforts

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; MHA Office of Adult Services; MHA Office of Child and Adolescent Services; other MHA staff; MHA Consultants; Alcohol and Drug Abuse Administration (ADAA); Managed Care Organizations (MCOs); Maryland Medicaid; CSAs; UMBC MDQuit Center; Community Behavioral Health Association (CBH); On Our Own of Maryland (OOOMD); MHAMD; MCF

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Under the auspices of SAMHSA's Leadership Academy for Wellness and Smoking Cessation Summit, a survey on clinical and support staff tobacco/smoking behaviors and attitudes toward consumer smoking/tobacco use among providers of behavioral health services in Maryland was developed. This survey was conducted between September 25<sup>th</sup> and November 15<sup>th</sup>, 2012 and included 146 behavioral health provider agencies (83 affiliated with MHA, 63 affiliated with ADAA). Survey participants included 556 clinicians/staff at PMHS provider agencies, and 340 clinicians and staff at substance abuse system provider agencies consisting of administrators, managers, therapists, social workers, psychiatrists, physicians, registered nurses and certified addictions counselors. Some training and educational material will be developed based on the survey results and will form the foundation of technical assistance to CSAs and local programs. Through the planning and implementation of the survey, MHA and ADAA forged a strong partnership on wellness and established a solid framework for integration on future projects of common interest.

One of the recent results is that new trainings have been added to the Maryland Tobacco Quitline protocols in which coaches undergo intensive training around Mental Health and Tobacco Cessation. The training is designed to help the coaches explore perceptions about: the Quitline; participants with mental health conditions (e.g. their ability to quit); and how these perceptions may have a negative impact on treatment outcomes. Written materials for training programs for clinical and staff at behavioral health provider agencies are being developed by the MDQuit Center for an integrated approach to smoking cessation. Additionally, the Mental Health and Tobacco Cessation educational materials will be added to Network of Care upon completion.

The Maryland Smoking Cessation Leadership Group, composed of physicians, clinicians, consumers, representatives of MHA, ADAA, and DHMH, provides Technical Assistance (TA) and guidance on multiple cessation strategies to the CSAs through the Maryland Association of Core Service Agencies (MACSA). The Tobacco Cessation Workgroup on Consumer Issues (comprised of consumers and representatives of the CSAs and advocacy organizations) is facilitating the establishment of community linkages between the CSAs and local Wellness & Recovery Centers. Through a vigorous community education project, awareness of the dangers of small, candy-flavored cigars for youth has been promoted across the state. MHA continues its collaborations with the MD QUIT Center of UMBC, which offers consultation to community providers, and to CSAs upon request, on utilization of toolkits.

Additionally, MHA worked with ADAA and DHMH's Center for Health Promotion, Education & Tobacco Use Prevention, to develop metrics for monthly StateStat submissions to measure: the number of adults and youth with behavioral health issues who are smoking; number of calls to the Maryland Tobacco Quitline; and number of nicotine replacement therapy materials distributed. These measures are being refined and sharpened.

At the Seventh Annual Best Practices Conference sponsored by the MDQuit Center in January 2013, MHA staff and consultants were recognized for their contributions to the success of the survey, which in turn contributed toward the receipt of two Pfizer Medical Education Grants received by the MDQuit Center for the development of single and multi-session group smoking cessation manuals and training enhancements to the existing 5 "A"s Methodology (Ask, Assess, Advise, Assist, & Arrange).

**Strategy Accomplishment:**

This strategy was achieved.

(1-2C)

Continue to implement, evaluate, and refine the Self-Directed Care project in Washington County and throughout the state.

Indicators:

- Self-directed care (SDC) plans developed and approved with peer support workers assisting consumers with the process
- Continued WRAP training of consumer advocates and consumer participants with an emphasis on stress reduction and wellness
- Person Centered Care Planning training introduced to consumer advocates and consumer participants for goal directed, person centered recovery initiatives
- Implementation of SDC explored in other jurisdictions as funding is available
- Increased Internet utilization – Network of Care and use of advance directives for mental health treatment

Involved Parties: MHA Office of Consumer Affairs; MHA staff; Washington County CSA and providers; ADAA Regional Services Manager; Wellness and Recovery Centers (WRC); OOOMD; consumers and family members

MHA Monitor: MHA Office of Consumer Affairs

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA implemented a consumer self-directed care pilot program in Washington County, managed through the local Office of Consumer Advocates. In FY 2013, the Self-Directed Care (SDC) program assisted 87 individuals with the development and implementation of their personal “recovery” plans. At any one time, 40-45 individuals are active with the program. Staffing consists of two full-time and one part-time Peer Advocate assisting consumers with the process. Though the process includes development of plans, advocates do much more than that. Quarterly, participants complete a self-assessment matrix that tracks their progress (and challenges) in a number of domains on their lives, including housing, income, education, employment interests, natural supports, etc. SDC also implemented the use of a stress scale that is done quarterly to determine the severity of difficulties that participants face in their lives. Many SDC participants have low incomes that contribute to housing and other difficulties. SDC also began developing regularly scheduled group activities in which participants support each other’s efforts in recovery, learn more about community information, socialize, and develop plans to address additional group needs.

Peer Advocates continue to help consumers develop and implement their recovery plans, which include directing the use of their benefits to access both public mental health services and non-traditional support services such as driver education, obtaining one’s driver’s permit and license, gym memberships, and continuing education classes. If needed, SDC consumer funds pay for non-traditional resources such as classes, project-related clothing, textbooks, etc. Several consumers are in college and on the Dean’s list. Person Center Care training was introduced in FY 2013 to consumer advocates and program participants to facilitate the development of goal directed, person centered recovery initiatives. However, the program did a great deal of work in FY 2012 to revamp the approach to participants and to make the documentation and intake process and forms more relevant and comprehensive. Additionally, individuals in the SDC program learn to independently manage their personal finances and are in various stages of developing or applying a plan for financial stability.

In FY 2013, SDC conducted Social Security work incentive workshops for SDC individuals and staff to advise them of how work incentives operate and how they can make use of them. One focus of the workshops was to dispel myths such as: one cannot work and apply for benefits at the same time or that there are few resources for individuals who do not have higher education.

As part of the Office of Consumer Advocates, Inc. (OCA, Inc.), an affiliate of On Our Own of Maryland that operates in Washington, Allegany, and Garrett counties, SDC has Peer Advocates who offer WRAP classes, as part of the contract deliverables, to the individuals who utilize OCA, Inc. services. The individuals in SDC have multiple life domain problems and stressors. When recently the life stressor scale was administered to individuals in the program, the scores averaged well over 70 out of a 100-point scale for high stress. WRAP and the other classes/ activities were offered which emphasize stress reduction and promote wellness and recovery. WRAP training and other activities offered to SDC participants assist them in identifying triggers, managing stress, etc. so that they can remain active in school/college/GED classes, physical health activities, etc. Additionally, training has been offered to staff to implement additional support when stressors occur.

Individuals who are active in SDC and other OCA, Inc. programs are encouraged to make use of the Wellness and Recovery Centers groups, classes and activities. SDC is scheduling monthly group sessions for SDC participants to share recovery stories, resource information, and to provide mutual support. SDC conducts home visits as needed to ensure that individuals are assisted with pursuing their recovery goals and working on their plans.

The Network of Care continues to be utilized as a resource to assist individuals with accessing benefits, with housing issues, and with developing advance directives as needed. Each person active in the OCA, Inc. programs (SDC, Peer Support and Advocacy, etc.) is provided a brochure of rights and responsibilities as well as a procedure for filing grievances.

**Strategy Accomplishment:**

This strategy was achieved.



(1-2D)

Expand on the efforts to embed a resilience-focused, strength-based approach to the provision and evaluation of child and adolescent mental health services through specific training on the core concepts of resilience, which promotes improved treatment outcomes and family engagement.

Indicators:

- Partnership with the University of Maryland on a Resilience Grant for Practice Improvement
- Resilience Committee meetings held to develop planned outcomes
- Number of Resilience Trainings requested and provided
- Efforts of the Resilience Committee expanded to include a wellness and prevention focus across the lifespan

Involved Parties: Joan Smith, MHA Office of Child and Adolescent Services; MHA Office of Consumer Affairs; University of Maryland School of Medicine, Department of Psychiatry; MHA Resilience Sub-Committee of the Maryland Blueprint Committee; ADAA; CSAs; family members, advocates, and providers; child-serving agencies

MHA Monitor: Albert Zachik, and Joan Smith, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Through a grant for practice improvement obtained by the University of Maryland and shared among multiple agencies, MHA established a Resilience Breakthrough Collaborative (RBC) which explored the process of moving from resilience theory to practice through the use of specific strategies geared toward system change, organizational resilience, clinical improvements and family and community resilience. The RBC was comprised of approximately 50 people, which included groups representing seven child and adolescent service providers from across the state, a planning team, faculty, and care givers. This work, done in partnership with the University of Maryland, was completed by June 30, 2013. However, trainings continue to be conducted through the MHA Resilience Committee (formed in FY 2006).

The RBC supported six child and adolescent providers making a commitment to embed resilience-focused efforts into their organizations and service delivery. This was done through a series of learning sessions, leadership and affinity calls, and on-line workspace. Also resulting from the RBC is the dissemination of materials including metrics, articles, treatment practices, power points, assessment scales, and efforts to support organizational resilience. Even though the RBC has ended, the participating providers have committed to continuing using the metrics developed.

Other efforts that were accomplished in FY 2013 included: provision of eight trainings to approximately 225 people; dissemination of a resilience poster translated in to Spanish; expansion of efforts to have a behavioral health and life span component (which includes having ADAA join the committee); and developing ongoing partnerships with the MHA's Office of Consumer Affairs (OCA).

The Resilience Committee continues to: provide trainings; meet on a monthly basis; and engage with people working with adults in recovery to incorporate resilience concepts (from a universal wellness and promotion effort to how outcomes for people in treatment are defined). The Resilience Committee has assisted Maryland in being chosen for the

Substance Abuse and Mental Health Services Administration (SAMHSA)-sponsored State Policy Academy on Prevention for youth and families). In September 2012, this Academy brought together state teams to build and enhance a systematic statewide prevention infrastructure focused on the developmental needs of young people from birth to age 24. The Maryland team developed recommendations and strategies on how to better infuse promotion, prevention and early intervention into its overall system of care. A Prevention Committee was formed as a result of the policy academy that continues to meet and develop common language and goals across state agencies as it promotes good health and resilience as an ultimate goal of interventions, treatment, and recovery. The Committee assisted in expanding the reach of the work being done through the Resilience Committee, as it includes representation from ADAA whenever possible.

MHA has long been committed to a Recovery and Wellness orientation among adults in the PMHS. While the Resilience Committee has centered its work on children and youth it is recognized that, from a behavioral health perspective, the overall focus on promoting resiliency is applicable whether as a strategy for promoting good mental health for everyone, or in helping people in treatment or recovery feel competent, and have hope for their future. The long term goal now is to blend these approaches from a behavioral health and life span focus so as to promote wellness, and optimal growth. Areas to explore will be: incorporating concepts into the DHMH Behavioral Health Integration Process; strengthening the partnership with MHA's Office of Consumer Affairs; and creating anti-stigma efforts and media messages that promote good mental health for all to make this more of a lifespan effort.

**Strategy Accomplishment:**

This strategy was achieved.

(1-2E)

Identify opportunities to assist older adults to maintain health, develop resilience, and participate in their communities.

Indicators:

- Promotion and implementation of Substance Abuse and Mental Health Services Administration's (SAMHSA's) "Treatment of Depression in Older Adults" Evidence-based Practices Tool kit
- Tool kit information disseminated to CSAs, Local Areas of Aging, local Department of Social Services (DSS), and other appropriate stakeholders through partnership with MHAMD's Coalition on Mental Health and Aging

Involved Parties: Marge Mulcare, MHA Office of Adult Services; MHAMD's Coalition on Mental Health and Aging; CSAs; Local Areas of Aging; local DSS offices

MHA Monitor: Marge Mulcare, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA and MHAMD promoted The "Treatment of Depression in Older Adults" tool-kit by informing providers, organizations, venues, and audiences such as the CSAs, Local Areas of Aging, DSS, and others of its on-line availability. SAMHSA encouraged individual interested parties to download the tool kit at no cost rather than distribute multiple copies. The tool-kit consists of evidence-based information such as how to develop and implement a suicide prevention project in community living programs, including nursing homes and assisted living facilities, adaptable for psychiatric rehabilitation programs (PRPs). It also contains mental health information on recognizing symptoms, warning signs, and prevention and intervention strategies.

Efforts are continuous to encourage the CSAs and provider system to include older adults in all health, wellness, recovery initiatives and activities, as well as to partner with their local areas on aging regarding participation in their chronic disease self-management programs.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 1.3. MHA will increase opportunities for consumer, youth, family and advocacy organizational input into the planning, policy, quality assurance, evaluation, and decision-making processes.**

(1-3A)

Participate in oversight of the Consumer Quality Team (CQT) project for statewide expansion.

Indicators:

- Continued statewide implementation, covering all of Maryland's regions and outlying jurisdictions
- Psychosocial programs and inpatient facilities in Maryland visited
- Feedback meetings held, identified issues resolved, and annual report submitted

Involved Parties: MHA Office of Consumer Affairs; Cynthia Petion, MHA Office of Planning and Training; MHA Office of Adult Services; Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Sharon Ohlhaber, MHA Office of Quality Management and Community Programs; State facility representatives; CSAs; MHAMD; MCF; the Maryland Association of Resources for Families and Youth (MARFY); NAMI MD; OOOMD; Community Behavioral Health Association of Maryland (CBH) University of Maryland Center for School Mental Health and the University of Maryland Systems Evaluation Center (UMD SEC); RTC Steering Committee

MHA Monitor: Cynthia Petion, MHA Office of Planning and Training and MHA Office of Consumer Affairs

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The CQT is a consumer-run organization, staffed by consumers and family members, which, in FY 2013, entered its sixth year of operation. It is a part of the Mental Health Association of Maryland (MHAMD) and supported by funding from MHA through the federal mental health block grant. CQT is authorized by MHA to conduct site visits, announced and unannounced, to programs in the Public Mental Health System (PMHS). During the site visits, consumers who volunteer are confidentially interviewed and share their concerns and satisfaction with the CQT. In FY 2013, CQT interviewed a total of 1,275 consumers as well as made 306 site visits to psychiatric rehabilitation programs (PRPs) and inpatient facilities. Feedback meetings were held to review issues, concerns and discuss resolutions with the facility/program directors, consumers, the CSAs, and MHA leadership. The project continues to protect and enhance rights by obtaining first hand information from consumers about their experiences in programs and takes an active role in resolving issues right at the program level and, as needed, at other system levels. Both consumers and program staff have reported significant program changes made as a result of the reports.

Last year, MHA re-located individuals living in on-campus assisted living units into the community. CQT assisted the MHA in the Spring Grove Hospital Center's Assisted Living Unit Discharge Project by building upon a survey administered to the residents prior to the move and interviewed them about needs met and satisfaction since the move. Of those interviewed, most expressed satisfaction with housing, transportation, work/volunteer opportunities, community activities, and increased interactions with family and friends.

Additionally, at the request of MHA, CQT undertook a project to interview consumers at Spring Grove Hospital who were identified as clinically ready for discharge, but resistant to community placement. Forty-one individuals were interviewed and all but one wanted to be discharged into the community. The Community providers found the information obtained in the interviews very helpful and the interviews were added to the consumer's medical records.

Recently, CQT received funding to expand its focus to include child and adolescent services beginning with site visits to eight private residential treatment centers (RTCs) and two Regional Institutes for Children and Adolescents (RICAs), as a part of the "RTC Retooling Project". A full-time Program Coordinator (Deputy Director of CQT) was hired to lead the planning activities for the development and implementation of the youth and family Consumer Quality Team. The primary function of her position is the development and implementation of the Children's program. Future site visits will also include the MHA RICA facilities. A RTC Steering Committee was formed with representatives from the Maryland Coalition of Families for Children's Mental Health (MCF), the Maryland Association of Resources for Families and Youth (MARFY), the University of Maryland School Mental Health Center, OOOMD, RTC Committee, MHA and MHAMD. Efforts are in the planning stages and will include young adults, who have received RTC or RICA services, as interviewers. Protocols for interviews with youth and families were developed and CQT is working with MHA to resolve issues with consent. As funding becomes available, the ultimate goal is to offer this initiative in all 24 jurisdictions and the remaining state-operated facilities.

**Strategy Accomplishment:**

This strategy was achieved.

(1-3B)

Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children's Mental Health (MCF) Family Leadership Institute for parents of children with behavioral disorders; youth leadership programs; and the Leadership Empowerment and Advocacy Project (LEAP).

Indicators:

- Annual MCF Family Leadership Institute (FLI) convened, training activities for families implemented, number of graduates
- Increased youth leadership participation in state and local policy committees and public awareness events
- LEAP redefined and expanded to include increased collaboration with deaf and /or hard of hearing adult leadership and participation at statewide trainings
- Increased consumer and family participation in state and local policy planning for behavioral health system of care

Involved Parties: Al Zachik and Tom Merrick, MHA Office of Child and Adolescent Services; Susan Kadis, MHA Office of Consumer Affairs; Marian Bland, MHA Office of Special Needs Populations; MCF; CSAs; OOOMD

MHA Monitors: Al Zachik, MHA Office of Child and Adolescent Services and MHA Office of Consumer Affairs

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

**Family Leadership Institute**

The Maryland Coalition of Families for Children's Mental Health (MCF) held its seventh Family Leadership Institute (FLI) in FY 2013 to train families to advocate for their children and all of Maryland's children in their communities and across the state.

Funding was provided through federal grants to MCF for FLI and its youth leadership development. In 2013, twenty-four individuals from 12 jurisdictions attended 12 sessions and 18 completed the program. The sessions included Friday nights so that attendees were able to develop relationships with the presenters, organizations representatives, and each other.

Twenty-three guest speakers presented to FLI and included representatives from MHA, the Developmental Disabilities Administration (DDA), ADAA, the Department of Human Resources (DHR), the Department of Juvenile Services (DJS), the Maryland State Department of education (MSDE), the Governor's Office for Children (GOC), Kennedy Krieger Institute, Public Policy Partners, and *Taking Flight* (a program for youth and young adult leadership development) among others. Among the topics presented were Maryland's System of Care, special education, and psychological evaluations.

This year's participants increased the total number of trained family advocates to 133 over the seven years of the Institute's implementation. As a result of the efforts over the years, FLI facilitated robust family, youth, and consumer involvement to further advocate for families, increased resources in the community, as well as increased participation in the major policy movement toward behavioral health integration and Medicaid reform currently in process in Maryland.

## **Youth and Young Adult Involvement**

MHA, in partnership with other federal grants, has supported *Taking Flight*, a joint program of the MCF and the OOOMD for youth and young adult leadership development. It is a youth council comprised of youth advocates ranging in ages from late teens to early twenties. Members are a diverse group of individuals with different backgrounds (mental health, foster care, lesbian, gay, bi-sexual, transgender, questioning (LGBTQ), etc). A goal is to draw upon experiences to advocate toward making positive system changes. A Youth Peer Support and Leadership Retreat, sponsored in part by OOOMD's Transition-Age Youth Outreach Project, was held in June 2013 with more than 40 participants. One of the members won a VOICE award for young adult leadership at the OOOMD conference. Additionally, two youth representatives testified before the Maryland Legislature against two bills that were stigmatizing toward individuals with mental illness.

Also, the MHA Child & Adolescent conference, held in March 2013, featured a young adult keynote speaker who inspired others through her narration of overcoming challenges in the mental health/foster care system to becoming a lawyer and leader in her community. The conference also included a young adult recovery panel consisting of three members of *Taking Flight* who discussed their journeys from challenging experiences to taking on current leadership roles. These recovery panels are available for presentation throughout the state and can be tailored at the request of the host.

Additionally as mentioned previously, CQT, authorized by MHA to conduct site visits and consumer interviews announced and unannounced to programs in the Public Mental Health System, received funding to expand its focus to include child and adolescent services. Future site visits will also include RTCs and the MHA RICA facilities. Efforts are in the planning stages and will include young adults, who have received RTC or RICA services, as interviewers. Protocols for interviews with youth and families have been developed.

## **LEAP**

The Consumer Affairs Liaison within the MHA Office of Consumer Affairs (OCA) is involved in coordinating and implementing the Leadership Empowerment Advocacy Project (LEAP) which has been funded by the MHA since 1990. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates while playing a prominent role within state and local policy-making bodies. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and to hold other consumer-related positions within the state.

In FY 2013, LEAP training took place during four sessions - May 6 and 24; June 11 and 24. The participants participated in workshops in the areas of recovery, assertiveness training, leadership skills, cross-disability advocacy, and the future of services under Medicaid. Twenty-eight participants from across the state graduated from the program. LEAP graduates continue to serve on committees, federal and state advisory boards; as well as participate in the state planning process for the Public Mental Health System.

## **Strategy Accomplishment:**

This strategy was achieved.

**GOAL II. PROMOTE A SYSTEM OF INTEGRATED CARE WHERE PREVENTION OF SUBSTANCE ABUSE AND MENTAL ILLNESS IS COMMON PRACTICE ACROSS THE LIFE SPAN.**

**Objective 2.1. MHA, in collaboration with Core Service Agencies (CSAs), the administrative services organization (ASO), managed care organizations (MCOs), behavioral health and health care providers, and other administrations and agencies, will continue to develop mechanisms to promote integrated health care.**

(2-1A)

Continue to facilitate coordination of care activities throughout the behavioral health system of care and study data to determine impact of wellness activities and coordination of care in the provision of community behavioral health services.

Indicators:

- Utilization of existing interagency data to facilitate coordination of care i.e. pharmacy data (PharmaConnect)
- Collaboration with Medicaid Pharmacy regarding prescribing practices of anti-psychotic medicine in children
- Utilization of the Coordination of Care Committee to coordinate care of complex dual diagnosis cases
- Increased access to registered somatic health providers through the administrative services organization (ASO) Web site and coordination of care activities administered through monthly meetings of medical directors of MHA and HealthChoice
- Integration of elements of coordination of care in behavioral health system of care through the Community Mental Health Medical Directors Consortium

Involved Parties: Lisa Hadley and Jean Smith, MHA/ADAA Office of the Clinical Director; MHA-MCO Coordination of Care Committee; Community Mental Health Medical Directors Consortium; Alcohol and Drug Abuse Administration (ADAA); MCOs; Medical Care Programs - Office of Health Services; ValueOptions@Maryland

MHA Monitor: Lisa Hadley, MHA/ADAA Office of the Clinical Director

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA continues to monitor data, develop wellness activities, and facilitate coordination of care throughout the system. Using the PharmaConnect system, pharmacy data are downloaded on a regular basis from the MHA administrative services organization (ASO) to the managed care organization (MCO) that provides somatic and substance abuse care to clients who are also receiving mental health services. Also, data mining continues within the Medicaid (MA) Pharmacy Program to identify utilization patterns.

The Medicaid Pharmacy system for Peer Review of antipsychotic medication use in children has been operationalized for children under age 10. This program includes automatic denial of reimbursement at the pharmacy level in order to curtail use of these atypical agents with children. MHA's Division of Child and Adolescent Services continues to collaborate with the Pharmacy Program on system implementation.



MHA is collaborating with the MHA-MCO Coordination of Care Committee, through monthly meetings, to determine barriers and strategies for integrated care and to identify universal outcomes. The Committee continues to review complex dual diagnosis cases at its regular meetings. Some of the coordination of care activities to address complex cases include: review of medication; making recommended changes; and identification and implementation of additional services that can be made available to individuals with complex case histories. MCO Care Managers consult with MHA staff and ASO staff about resource availability.

Access to registered somatic health providers has been increased through Webinars and trainings that are available through the ValueOptions®Maryland Web site. Training events are posted on the ASO site, which can be viewed by all providers, as well as the public. Regional forums have been held by the ASO on Integration of Care. Trainings are also available on how to access the Outcome Measurement System (OMS) data.

Meetings of medical directors of MHA and HealthChoice MCOs have been discontinued, due to the MCOs' participation in the series of stakeholder meetings related to the DHMH Behavioral Health Integration process.

Members of the Community Medical Directors Consortium have participated in the review and the development of its new Quality Incentive Program (QuIP) for outpatient mental health centers. QuIP is a comprehensive plan for monitoring provider utilization and expenditures. This program is being piloted by the ASO, in collaboration with MHA.

**Strategy Accomplishment:**  
This strategy was achieved.

(2-1B)

Participate in DHMH's Behavioral Health Integration Steering Committee and workgroups (Linkages, Evaluation and Data, State/Local/Non-Medicaid, and Chronic Health Home) to support the selection of the behavioral health financing and systems integration model.

Indicators:

- MHA represented on DHMH's Committee and workgroup meetings
- Input provided toward development of model of care
- Information disseminated to appropriate stakeholders

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; ADAA; Medicaid; MHA and ADAA staff as appropriate; providers; consumer and advocacy organizations

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA's Executive Director chaired the Linkages Workgroup and the Deputy Director co-chaired the State/Local/Non-Medicaid workgroup with ADAA's Acting Executive Director. MHA's Executive Director and Deputy Director also served as members of the Integration Steering Committee. In November 2012, recommendations from the

Behavioral Health Integrated Regulations Workgroup were forwarded to the DHMH Secretary. Also in November 2012, a proposed model for behavioral health financing was recommended to the Secretary. To develop the recommendation, input was received from the workgroups as well as community stakeholders. The Secretary of DHMH and DHMH leadership presented the proposed model and discussed options during the 2013 legislative session.

Information and meeting minutes were disseminated to stakeholders via the Behavioral Health Integration (BHI) Web site and electronic mailings. The Department is currently in Phase 3 of the BHI process. MHA, ADAA, and Medicaid have begun working on a Request for Proposals (RFP) for the new administrative services organization (ASO) which will outline aspects of the new Public Behavioral Health System (PBHS). Also, DHMH is holding stakeholders meetings to allow members of the public to provide input into the RFP process and to the decisions related to the integration process such as the role of the local agencies and non-Medicaid aspects. Additionally, MHA continues to work with ADAA and DHMH's Deputy Secretary for Behavioral Health and Disabilities to develop an organizational model for the new behavioral health administration.

The Office of the Secretary will submit a Joint Chairmen Report (JCR) outlining DHMH's final recommendations to the legislature by December 1, 2013. A draft JCR will be submitted in November 2013 for public comment.

**Strategy Accomplishment:**

This strategy was achieved.

(2-1C)

In collaboration with the University of Maryland's Schools of Medicine and Pharmacy, implement practice guidelines to ensure appropriate pharmacological utilization for adolescents and children with serious emotional disorders with focus on youth in Baltimore foster care system and for Medicaid recipients under age five across the state.

**Indicator:**

- Pharmacological practice guidelines defined and implemented
- Number of cases reviewed

**Involved Parties:** Al Zachik, MHA Office of Child and Adolescent Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; other MHA staff; Maryland Medical Programs (DHMH); the University of Maryland Department of Child and Adolescent Psychiatry; University of Maryland School of Pharmacy; Department of Human Resources (DHR); CSAs; Maryland Department of Juvenile Services (DJS); the Maryland State Department of Education (MSDE); the Maryland Coalition of Families for Children's Mental Health (MCF); Community Behavioral Health Association of Maryland (CBH); and other interested parties

**MHA Monitor:** Al Zachik, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In order to address the concerns that an increasing number of children are being prescribed antipsychotic medicines without sufficient monitoring, the DHMH Medicaid Pharmacy Program (MMPP) implemented a peer-review authorization process to ensure safe and effective use of antipsychotic medication. The goal of the program is to ensure that children and adolescents receive optimal treatment in conjunction with appropriate non-pharmacological measures in the safest manner possible.

The MMPP's Board-Certified child psychiatrist oversees the project. This program, which began in October, 2011, initially addressed the use of antipsychotics in Medicaid (MA) patients under five years of age. In July 2012, it expanded to encompass children under ten years of age. In 2013, the program began to include all children under the age of 18 in a gradual expansion process implemented over a six-month period. The program works in partnership with University of Maryland School of Pharmacy and the Division of Child and Adolescent Psychiatry.

Since the program's inception in 2011 more than 1,900 children have been treated by 369 prescribers (a large portion comprised of psychiatrists and psychiatric nurse practitioners).

In addition, contracts have been established with the University of Maryland at Baltimore, for implementation through its School of Pharmacy, to review Baltimore City child welfare caseload for their pharmacological utilization; linking psychotropic medication usage with the Department of Social Services (DSS) Chessie data and Maryland public health and pharmacy claims data for youth in the Baltimore City DSS out-of-home placements.

**Strategy Accomplishment:**

This strategy was achieved.

(2-1D)

Continue to interface and maintain liaison efforts and partnerships with other agencies and administrations to support a comprehensive system of behavioral and somatic health services and community supports.

Indicators:

- Collaborations established and implemented with state entities

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

- **Maryland Department of Disabilities (MDOD)**, Brian Hepburn, Liaison – MHA continues to collaborate with MDOD in the development and implementation of cross-agency initiatives such as Money Follows the Person, transition-age youth projects, and the identification of action steps to promote affordable housing efforts. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Maryland Department of Aging (MDoA)**, Marge Mulcare, Liaison - The Maryland Mental Health Association's "Coalition on Mental Health and Aging" serves as the vehicle through which representatives of various state agencies, CSAs with geriatric staff specialists, and other key stakeholders meet regularly to confer regarding older adults with mental illness, and to consult on various issues of aging.
- **DHMH Developmental Disabilities Administration (DDA)**, Stefani O'Dea, Liaison - MHA/DDA/ADAA bi-weekly clinical and leadership meetings continue as well as meetings among DDA staff, state hospital staff, and, on request, community-based Public Mental Health System (PMHS) providers. MHA continues to serve on the following boards and committees related to needs of consumers with traumatic brain injury (TBI): Maryland TBI Advisory Board; TBI Waiver Advisory Committee; and TBI Waiver Provider Meetings. Also, in FY 2013, the forensic offices of MHA, ADAA, and DDA have been combined into one office overseen by the DHMH Director of Forensic Services. DDA is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department of Public Safety and Correctional Services (DPSCS)**, Marian Bland, Liaison - The Office of Forensic Services (OFS) interfaces and works collaboratively with DPSCS. OFS and DPSCS staff serve on the Criminal Justice Information and Advisory Board and continue to collaborate with DPSCS on Criminal Justice Information System (CJIS) standards and measures. OFS staff is finalizing fingerprinting protocols to assist in the reduction of issuing hospital warrants of state psychiatric patients. MHA co-chairs the Mental Health and Substance Abuse subcommittee for the Maryland Correctional Administrators' Association (MCAA). Also, MHA through DHMH, collaborated with DPSCS, beginning in March 2013, for the implementation of the Reach-in Program which provides assessment of community needs and develops case management plans to prepare for a successful transition to the community.

In FY 2013, the Memorandum of Understanding between DHMH and DPSCS on the DataLink Project, which links information between the mental health system and the corrections system, has been executed for Baltimore City and Howard County. MHA also partners with the DPSCS for Chrysalis House Healthy Start Program which gives services and supports to women in the correctional system who are dually diagnosed and have trauma issues and who are pregnant or mothers of infants. The Director of the DHMH Office of Forensic Services (OFS) co-chairs the meetings of the Interagency Forensic Services Committee of the Maryland Advisory Council on Mental Hygiene/Planning Council.

- **Judiciary of Maryland**, The Office of Forensic Services (OFS) continues to interface and participate on joint projects with the Maryland Judiciary. OFS provides training to the judiciary on various forensic issues. OFS and members of the Judiciary collaboratively work on the Interagency Forensic Services Committee-Maryland Advisory Council/Planning Council. OFS continues to work with the Judiciary on issues affecting the Mental Health Courts.
- **Department of Juvenile Services (DJS)**, The OFS collaborates with DJS on juvenile cases that are forensically involved. The OFS Chief of Juvenile Pre-Trial Services participates in identified joint meetings, symposiums, etc with DJS. MHA meets every two weeks with multi-agency review teams (DSS, MSDE, and DJS) and OFS provides training to DJS and to judges, on issues affecting forensically involved juveniles. Also, MHA collaborates with DJS's interdepartmental workgroup to follow-up on recommendations for the behavioral health needs of adolescent girls. OFS monitors competency evaluations for children conducted in Jessup and holds meetings every 90 days to review protocols.
- **DHMH Office of Health Care Quality (OHCQ)**, Audrey Chase and Sharon Ohlhaver, Liaisons – MHA collaborates with OHCQ in relation to regulatory and compliance meetings and activities. In addition, MHA and OHCQ have both participated in a Behavioral Health Regulations Integration Workgroup during the year. Program-specific issues and issues related to regulatory interpretation and compliance continue to be discussed and addressed.
- **Governor's Office of the Deaf and Hard of Hearing (ODHH)**, Marian Bland, Liaison - MHA participates on the ODHH Behavioral Health subcommittee. MHA provides assistance with review of proposals as well as technical assistance on mental health and other behavioral health issues. MHA also provides information to ODHH annually on the number of individuals who are deaf or hard of hearing admitted to Springfield Hospital Center's unit for deaf individuals.
- **Department of Veterans Affairs (MDVA)**, MHA Office of Special Needs Populations, Liaison - MHA collaborates with the Department of Veterans Affairs through its participation on DHMH's Veterans Advisory Committee and with the Supplemental Social Security, Outreach, Access, and Recovery (SOAR) initiative. Through the Homeless ID Project, a case manager is funded to work with the Baltimore VA to complete SOAR application for homeless veterans who have mental illnesses or co-occurring substance use disorders. DHMH also administers the Maryland Commitment to Veterans Initiative, which partners with Veterans Affairs (VA) to address the behavioral health needs of veterans.
- **Department of Human Resources (DHR)**, Marian Bland, and Albert Zachik, Liaisons – MHA collaborated with DHR to locally implement the state's SOAR program and supportive services match for Shelter Plus Care grants. The Department of Human Resources is an active participant on MHA's SOAR State Planning Workgroup. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department of Housing and Community Development (DHCD)**, Russell Springham and Marian Bland, Liaisons - MHA coordinates with DHCD to facilitate applications for funding through the Housing and Urban Development (HUD) Continuum of Care. MHA participates on DHCD's applicant review panel for agencies seeking emergency and transitional funding. MHA also works collaboratively with DHCD as a part of the Maryland Partnership for Affordable Housing for the Implementation of new Section 811

vouchers and Weinberg units. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Governor's Office For Children (GOC)/ Children's Cabinet**, Tom Merrick, Liaison – GOC and MHA are active partners in implementing the Wraparound through care management entities (CMEs). As an active participant of the Children's Cabinet, MHA meets regularly with senior staff from the participating child-serving agencies to plan services across agencies for children, youth, and families. The Children's Cabinet Interagency Plan is monitored each year and intersects with MHA's ongoing planning processes.
- **Division of Rehabilitation Services (DORS)**, Steve Reeder, Liaison – Joint efforts included implementation of the evidence-based practice model of supported employment (SE) and the dissemination of shared data and outcomes. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Maryland State Department Of Education (MSDE)**, Albert Zachik and Cyntrice Bellamy, Liaisons – MHA meets with the Assistant Superintendent for Special Education at MSDE to collaborate on mutual concerns involving the mental health needs of children in school and early childhood settings. This department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department Of Family Health Administration (FHA) DHMH Prevention and Health Promotion Administration [formerly Family Health Administration and Environmental Health and Infectious Disease Administration]**, - Al Zachik, Marian Bland and Darren McGregor, Liaisons – MHA collaborates on Maryland's implementation of the Nurse-Family Partnership® (an evidence-based, nurse home visiting program for low-income, first-time parents and their children), Project Maryland LAUNCH (which increases the use of early screenings, assessments, and mental health consultations; increases integration of behavioral health and primary care; enhances home visiting; and provides family strengthening and parent skills training), and works closely with the administration on the Early Childhood Mental Health. MHA participates on the HIV Planning Group along with Prevention and Health Promotion and ADAA to develop strategies to reduce risk of HIV infection. The group identifies populations with potential higher risks including individuals with mental illness and justice-involved individuals.
- **Maryland Emergency Management Agency (MEMA)**, Brian Hepburn, Liaison – MHA continues its partnership with MEMA (the state agency responsible for mass care and shelter), DHMH's Office of Preparedness and Response, MDOD, and DHR. Ongoing trainings and presentations are offered to state facilities and involved state agencies.
- **DHMH Office of Capital Planning, Budgeting, and Engineering Services**, Cynthia Petion and Robin Poponne, Liaisons – MHA, in collaboration with this Office, processes requests for the DHMH Administration-Sponsored Capital Program (Community Bond) which provides capital grant funds for prioritized community-based services such as the development of affordable housing for individuals with serious mental illnesses.
- **Maryland Health Care Commission (MHCC)**, Brian Hepburn, Liaison – MHA collaborates with MHCC on health policy studies involving mental health services, reimbursement rates for hospitals, and issues involving health insurance coverage and the uninsured population.
- **Health Services Cost Review Commission (HSCRC)**, Brian Hepburn, Liaison – MHA and HSCRC meet periodically to update the rate-setting process for hospital rates for inpatient services.

- **DHMH Alcohol and Drug Abuse Administration (ADAA)**, Carole Frank, Liaison - MHA collaborates under the auspices of DHMH's Behavioral Health and Disabilities with ADAA in the ongoing efforts of Behavioral Health Integration. Partnerships were enhanced in planning MHA's Annual Conference and the state Mental Health Plan Development Meeting. The Director of ADAA Training and MHA Chief of Training continued to plan events and attend each others' conferences. Trainings were conducted for both agencies' supervisors, peer workers and providers. Additionally, both training authorities continue to work together on a Co-Occurring Disorder Workgroup with the Developmental Disabilities Administration focused on achieving Dual Diagnosis Capability in these administrations. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council
- **DHMH Medical Care Programs**, Brian Hepburn, Lisa Hadley, and Daryl Plevy, Liaisons – MHA participates in the Maryland Medicaid (MA) Advisory Committee and in the Medical Care Organizations' (MCOs) monthly medical directors meetings. MHA works with Maryland's MA program on issues and state plan amendments (SPAs) such as Money Follows the Person, the 1915(i) SPA for Children, Youth, and Families, telemental health services, and the Medicaid Emergency Psychiatric Demonstration. Since 2011, DHMH has been spearheading efforts to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues". The Deputy Secretary of Health Care Financing has been leading this charge and the Behavioral Health Integration Process is well underway. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 2.2. MHA will work with the CSAs and other stakeholders to develop, implement, and evaluate screening, prevention, and early intervention services across the life span for individuals with psychiatric disorders or individuals who are at risk for psychiatric disorders.**

(2-2A)

In collaboration with the Maryland State Department of Education (MSDE), the Center for Maternal and Child Health, the Maryland Blueprint Committee, the University of Maryland, and other stakeholders continue to build infrastructure and deliver training to improve the quality of mental health screening assessment and intervention for young children.

**Indicators:**

- University of Maryland Early Childhood Mental Health Certificate program expanded to Bachelor's level participants – An additional 20 professionals trained
- Summary of implementation data from the the Social and Emotional Foundations for Early Learning (SEFEL) reviewed

**Involved Parties:** Al Zachik, MHA Office of Child and Adolescent Services; MSDE; Center for Maternal and Child Health; the Maryland Blueprint Committee

**MHA Monitor:** Al Zachik, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The goal of the Early Childhood Mental Health Certificate Course program is to train clinicians, consultants and providers in core competencies, knowledge, attitudes and skills needed in infant and early childhood mental health practices, assessment and treatments. The faculty continues to represent experts from leading regional institutions, including Johns Hopkins University, Kennedy Krieger Institute, Georgetown University, Mental Hygiene Administration, and the Maryland Coalition of Families. The Certificate program trained an additional 16 participants in FY 2013. Individuals completing the program, since its beginning, number 163. Participants ranged geographically from across the state (eastern shore [Salisbury] to Western Maryland [Washington County]) and even Virginia. Participants were masters level prepared and represented a variety of disciplines including child care, mental health, education, social work, counseling, and nursing (nurse practitioners). Resources to expand to a Bachelor Level Certificate program are not available at this time. During this cohort, there was the development of improved on-line features of the course and communication strategies to support participants' efforts to complete the course, as well as gain access to other relevant materials and updates.

The Social and Emotional Foundations of Early Learning (SEFEL) initiative is an approach toward building a consistent, evidence-based professional development framework for the early care and education workforce through the provision of training and technical assistance to state teams, demonstration sites, trainers, coaches, etc. The Maryland State Department of Education (MSDE) and the University of Maryland School of Social Work's Institute for Innovation and Implementation have made several improvements and updates to the new SEFEL Web site. Three of the four preschool training modules are available with the fourth module projected to go live in November 2013. The infant and toddler modules are on track to go live in December 2013. To date, over 125 people have taken the first module. In addition to the training, the Web site contains several useful pages for families, teachers, and trainers. Links to national and Maryland specific Web sites are also included to allow access to a wealth of information about activities and ideas for promoting children's social and emotional wellness. Future plans include adding connections to local jurisdictions, a guide that will provide SEFEL strategies that tie in with the new Early Learning Standards, and a data collection Web site aimed at assisting sites in implementing SEFEL to fidelity in their programs.

SAMHSA's Project LAUNCH Grant was awarded to MHA in September 2012 and serves as an additional avenue to build infrastructure and improve the quality of services for young children. Project LAUNCH is designed to support states development of an early childhood system of care for young children and their families and focuses on implementing strategies that promote young child wellness and support a coordinated system of care for young children. Prince George's County was identified as the local community in which to implement specific strategies in the following five areas:

1. Developmental Screening and Assessment
2. Enhancement of Home Visiting Services
3. Early Childhood Mental Health Consultation
4. Behavioral Health Integration into Primary Care
5. Family Support and Parent Education



Initial contracts were completed with Prince George's County in order to hire a local coordinator and support staff as well as initiate the start of direct services in targeted communities within Prince George's County.

**Strategy Accomplishment:**

This strategy was partially achieved.

(2-2B)

*\*Federal Mental Health Block Grant*

MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.

**Indicators:**

- Annual MHA Suicide Prevention conference conducted with inclusion of training sessions on issues/needs of special needs populations such as veterans and lesbian, gay, bi-sexual, transgender, questioning (LGBTQ)
- Education and outreach activities implemented to promote awareness and resource development
- Recommendations implemented from the Governor's Commission on Suicide Prevention final report

**Involved Parties:** Brian Hepburn, MHA Office of the Executive Director; Al Zachik, Cyntrice Bellamy, MHA Office of Child and Adolescent Services; Cynthia Petion, MHA Office of Planning and Training; MHA Office of Adult Services; Maryland Department on Aging; The Maryland Crisis Hotline Network; The Maryland Committee on Youth Suicide Prevention; Wellness and Recovery Centers (WRCs); MSDE; CSAs; Johns Hopkins University; University of Maryland; local school systems; other key stakeholders

**MHA Monitors:** Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

On October 7, 2009, Governor Martin O'Malley issued Executive Order establishing the Governor's Commission on Suicide Prevention. Over the course of the last three years, 21 Commissioners brought together their professional expertise and personal experiences with suicide and its consequences to craft a set of recommendations. The work of the Commission was aligned with national suicide prevention efforts, especially in the state's historic and continuing emphasis on youth suicide prevention. The Commission's Plan, which was submitted in October 2012, also put forth a strengthened focus on preventing suicide, not only with high risk groups such as veterans, lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals, and persons who are unemployed; but also at critical high-risk periods, such as the aftermath of an unsuccessful suicide attempt.

The Commission's Plan has set the future direction of Maryland's suicide prevention efforts by defining three primary goals. Each emphasizes the science base of suicide prevention as well as the cultural competence, effectiveness and accessible nature of all outreach, services, and supports.

The Plan's three Goals are:

1. Increase and broaden the public's awareness of suicide, its risk factors, and its place as a serious and preventable public health concern
2. Enhance culturally competent, effective, and accessible community-based services and programs
3. Assure effective services to those who have attempted suicide or others affected by a suicide attempt or completion

The Commission's work provides clear priorities and achievable strategies for the organization, delivery, and funding of suicide prevention, intervention and post-vention services, across the state, for years to come.

Efforts to implement the goals of the Commission, across the lifespan, continue. MHA, under the purview of MHA's Office of Child and Adolescent Services, further promotes public awareness and education on suicide prevention and the availability of resources within communities through the following venues:

- Annual MHA Suicide Prevention conference conducted with inclusion of training sessions on issues/needs of special needs populations such as veterans and individuals who are LGBTQ. In FY 2013, the conference took place in October 2012
- Continued collaboration with the CSAs and other stakeholders and continued efforts to address and implement suicide prevention activities for persons across the lifespan
- Education and outreach activities implemented to promote awareness and resource development such as provision of outreach to faith based organizations and private human services organization
- Support of the work of the Maryland Hotlines, as well as their efforts to provide ongoing outreach to persons within their communities

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 2.3. MHA, in collaboration with the CSAs and other stakeholders, will continue to facilitate the development, implementation, and evaluation of services that address the needs of children, adolescents, transition-age youth with psychiatric disorders, and their families.**

(2-3A)

MHA, in collaboration with Maryland Department of Disabilities (MDOD), Department of Human Resources (DHR), Maryland State Department of Education (MSDE), and other stakeholders, will develop a plan to sustain integrated home and community-based services and supports for youth and young adults in transition following the conclusion of the Healthy Transitions Initiative demonstration project in Washington and Frederick Counties.

Indicators:

- Strategic and operational plans developed
- Involved systems and services identified and eligibility criteria reviewed
- Fifty (50) youth and young adults in transition served during the fiscal year

Involved Parties: Tom Merrick, MHA Office of Child and Adolescent Services; Steve Reeder, MHA Office of Adult Services; MDOD; MSDE; CSAs; DHR; MCF; Governor's Interagency Transition Council for Youth with Disabilities; the University of Maryland; Maryland Department of Rehabilitative Services (DORS), Maryland Seamless Transition Collaborative, and University of Maryland School of Medicine, Department of Psychiatry, Division of Child & Adolescent Psychiatry; University of Maryland-Evidence Based Practice Center; NAMI MD; OOOMD; local school systems; parents; students; advocates; other key stakeholders

MHA Monitors: Tom Merrick, MHA Office of Child and Adolescent Services and Steve Reeder, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The Healthy Transitions Initiative (HTI) demonstration project develops and provides integrated home and community-based services and supports for Transition-Age Youth through the pilot program in Washington and Frederick counties. During FY 2013, the program served 76 youth and young adults. The contracted provider of services, Way Station Inc., collaborates with MHA, HTI leadership, and community organizations to provide integrated home and community-based services to youth, young adults, and parents/caregivers in both counties.

The project is entering the final year of its five-year funding period and is being sustained and expanded through collaborative activities among MHA, Maryland Department of Disabilities (MDOD), Maryland State Department of Education (MSDE), Maryland Department of Rehabilitation Services (DORS), and other relevant stakeholders. Referral protocols have been established linking youth and young adult serving agencies with the Public Mental Health System (PMHS). The State Project director has relocated to University of Maryland Evidence Based Practice Center (UMD EBPC) to more readily facilitate expansion and sustainability. Efforts are underway to expand the HTI model and service provision methodology to the Mid-Shore region, Baltimore City, and Anne Arundel County. Plans are being made to include all MHA-funded Transition-Age Youth (TAY) programs in the state.

HTI continues to facilitate training and educational events on local, state, and national levels to increase awareness and understanding of transition-related issues of youth and young adults with mental health disorders.

**Strategy Accomplishment:**

This strategy was achieved.

(2-3B)

*\*Federal Mental Health Block Grant*

Implement the provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant from the Center for Medicare/Medicaid Services (CMS) to examine and refine Care Management Entity (CME) approaches.

**Indicator:**

- Continued development of a consistent model for family peer support
- Financing approach identified for populations served by CMEs
- A crisis response and stabilization model identified
- Coordination of CME service recipients' somatic and oral health improved consistent with wellness and Early and Periodic Screening Diagnosis and Training (EPSDT) standards of care
- Timely submission of data to Center for Health Care Strategies (CHCS)

**Involved Parties:** Al Zachik, MHA Office of Child and Adolescent Services; the Maryland Child and Adolescent Mental Health Institute; the University of Maryland; Department of Juvenile Services (DJS); Department of Human Resources (DHR); CMS; MCF; CHCS; State of Georgia; State of Wyoming

**MHA Monitor:** Al Zachik, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Maryland's CHIPRA Quality Demonstration Grant is the only behavioral health grant, among all those awarded by the federal Center for Medicare/Medicaid Services (CMS), that focuses on the implementation, expansion, and sustainability of Care Management Entities (CMEs) with continuing exploration of growth of the CME structure for home and community-based services. This is a five year grant, currently past the mid-point of implementation.

The Maryland Coalition of Families for Children's Mental Health (MCF) has also been contracted to provide education and support about access to somatic and dental care for families enrolled in CMEs. An oral health curriculum is in the process of development and CMEs have been monitored on their compliance with coordination objectives with Primary pediatric care for cases they serve.

During FY 2013, the 1915 (i) State Plan for Home and Community-based Services (HCBS) has been developed, in conjunction with MCF, for submission to CMS under CHIPRA to sustain CME approaches. The 1915 (i) state plan amendment became available for public comment prior to its FY 2014 submission. The document includes rate structures for family support developed under 1915(i) which are designed to financially support peer-to-peer activities by families.

All data with regard to CHIPRA deliverables have been submitted to the Center for Health Care Strategies (CHCS) and CMS in a timely manner. Additionally, a report on crisis and stabilization services for children, adolescents, and their families was developed and finalized. This work has been integrated with the crisis response system in Maryland.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 2.4. MHA will collaborate with CSAs and stakeholders to promote screening for mental health disorders, improve access and quality of services in a behavioral health system of care for individuals with co-occurring disorders, and provide linkages to appropriate treatment and supports across the life span.**

(2-4A)

*\*Federal Mental Health Block Grant*

In collaboration with DHMH and ADAA, continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment.

**Indicators:**

- Technical assistance (TA) provided to Core Service Agencies requesting assistance in promoting Dual Diagnosis Capability (DDC) within their jurisdictions
- Training and consultation for agencies requesting assistance in implementing practice changes which promote agency-wide DDC
- Continued TA to the substance abuse specialists and team leaders on Assertive Community Treatment (ACT) teams to enhance DDC of those teams
- Ongoing training for behavioral health providers on the use of scientifically-validated screening and assessment instruments in support of screening for and assessment of co-occurring disorders
- Provision of training and TA on Person Centered Care Planning (PCCP) principles and practices, within the context of county and agency substance abuse and mental health services integration projects

**Involved parties:** Carole Frank and Cynthia Petion, MHA Office of Planning and Training; MHA Office of Adult Services; MHA Office of Consumer Affairs; Eileen Hansen and Tom Godwin, the University of Maryland Evidence Based Practice Center (UMD EBPC); the Behavioral Health Systems Improvement Collaborative (BHSIC); ADAA; CSAs; Health Department Staff; ACT teams; mental health providers; Substance Use Disorders (SUD) Specialists; consumers and family members

**MHA Monitor:** Carole Frank, MHA Office of Planning and Training

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA has provided ongoing leadership in support of increasing Dual Diagnosis Capability (DDC) on many levels. Collaborative efforts have been encouraged with other agencies outside of and within DHMH, particularly with ADAA. A number of existing mental health treatment and rehabilitation programs, as well as programs established through ADAA, have developed DDC and are able to improve service delivery to individuals with co-occurring disorders.

In FY 2013, ongoing training consultation and TA was provided across the state by the University of Maryland Evidence-Based Practice Center (UMD EBPC) consultant and trainer for co-occurring disorders (CODC/T).

Throughout Maryland, support was provided to several CSAs and provider agencies to promote program assessment through utilization of Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capabilities in Mental Health Treatment (DDCMHT) instruments. The CODC/T assisted agencies with analysis of aggregate data collected through the multiple assessments completed. Based on assessments, trainings were further implemented to improve provider capacity. Trainings included Person Centered Care Planning (an approach designed to enable people to direct their own plan for services and supports).

Additionally, ongoing help and support has been provided to Assertive Community Treatment (ACT) Teams throughout the state. In FY 2013, there were 33 participants (including ACT Team leaders and Substance Use Disorders [SUD] Specialists) in a one-day training on the American Society for Addiction Medicine (ASAM) six dimension assessment format.

**Strategy Accomplishment:**

This strategy was achieved.

(2-4B)

MHA and the University of Maryland Systems Evaluation Center (UMD SEC) will analyze data relating to utilization of services in a behavioral health system of care by individuals with co-occurring disorders to further inform system and service planning and identify areas for quality improvement activities.

**Indicator:**

- Analysis conducted of consistency between diagnosis and self or provider report upon initial authorization of services in the Outcomes Measurement System (OMS) population

**Involved parties:** Cynthia Petion, MHA Office of Planning and Training; Susan Bradley, MHA Office of Management Information System (MIS) and Data Analysis; UMD SEC; University of Maryland Evidence Based Practice Center (UMD EBPC); ValueOptions®Maryland

**MHA Monitors:** Cynthia Petion, MHA Office of Planning and Training and Susan Bradley, MHA Office of MIS and Data Analysis

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

OMS data is captured and reported monthly on public web-based datamart. UMD SEC has utilized the Outcome Measurement System (OMS) data as it relates to those with a co-occurring substance abuse and mental health disorder to develop reports such as DataShorts and other efforts to inform planning.

The UMD SEC has continued to refine the OMS datamart and focus on comparing and contrasting the OMS change over time data results for consumers who have a co-occurring substance abuse disorder with consumers who do not have a co-occurring substance abuse diagnosis.

**Strategy Accomplishment:**

This strategy was achieved.

(2-4C)

*\*Federal Mental Health Block Grant*

Plan a system of integrated behavioral health promotion, prevention, and treatment services for children, youth, and young adults who are at risk for, or have mental health and/or substance abuse disorders.

**Indicator:**

- Develop and submit to MHA and the federal Substance Abuse and Mental Health Services Administration (SAMHSA) a strategic plan for child and adolescent behavioral health integration in the context of DHMH's behavioral health integration process
- Utilize the support of the SAMHSA-funded System of Care expansion grant to accomplish the planning process

**Involved Parties:** Al Zachik, MHA Office of Child and Adolescent Services; MHA Staff; ADAA; CSAs; Health Departments; providers; youth and young adults; consumers; families; advocates

**MHA Monitor:** Al Zachik, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In the fall of 2011, SAMHSA awarded Maryland a one-year System of Care (SOC) Planning Grant for approximately \$600,000 to help plan and support the development of an integrated behavioral health system of care for children, youth, and their families with mental health and substance use issues. The Maryland Behavioral Health Collaborative was established as a part of this grant to serve as an advisory committee to the planning effort. Under the first year of this grant, in addition to the advisory committee, a Management Team was convened and sub-committees formed to develop work plans, which were used to develop the draft Behavioral Health Strategic Plan. A sub-committee on Wellness incorporated elements of the Institute of Medicine (IOM) prevention framework within its recommendations for the plan.

A no-cost extension was awarded to the state for 12 additional months (until September 30, 2013) to further plan and develop a statewide SOC and assess training and workforce development needs to support the efforts related to the DHMH Behavioral Health Integration (BHI) process. The Maryland Behavioral Health Collaborative submitted a final Behavioral Health Strategic Plan for BHI for children and adolescents, a deliverable of the grant, to SAMHSA as required. The plan lays out a broad set of guidelines and is, in effect, a “plan to plan” as the DHMH BHI takes place. The Plan has eight major goals which include: wellness; screening and assessment; adequate service package; quality improvement; workforce development; policy planning; and social marketing. A statewide stakeholder meeting will be held in mid-September 2013 to solicit stakeholder input into the plan. Results of that feedback will be tabulated in early FY 2014. The work for this grant was completed.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 2.5. MHA will closely monitor the activities of national and state health reform and prepare and plan appropriate coordination and collaboration.**

(2-5A)

Improve communication and efforts that support activities that lead to implementation of behavioral health integration and coordination of care in the delivery of services to individuals with mental illnesses.

**Indicators:**

- Network of providers educated about Health Care Reform, through DHMH and MHA Web sites, MHA conference, Webinars, and Community Mental Health Directors meetings
- Participation on DHMH behavioral health integration workgroups
- Activities of community mental health providers who are integrating somatic care into their services monitored and supported

**Involved Parties:** Brian Hepburn, MHA Office of the Executive Director; MHA Office of the Clinical Director; Cynthia Petion, MHA Office of Planning and Training; Melissa Schober, MHA Medicaid Policy Analyst; CSAs, Center for Medicare/Medicaid Services (CMS); Maryland Medicaid (MA); other mental health consumer and family advocacy groups; CBH; other stakeholders

**MHA Monitors:** Brian Hepburn, MHA Office of the Executive Director



**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In light of the passage of the Affordable Care Act (ACA), a kick-off session took place in March 2012 to initiate the process of choosing a new Medicaid financing structure and model that improves the integration of Medicaid-financed behavioral health. This process of selecting an integration model for Medicaid-financed behavioral health services is comprised of three phases.

- The first phase began back in 2011 and involved collaborative work between the Department, a consultant, and stakeholders in order to assess the strengths and weaknesses in Maryland's current system.
- Phase 2 of the process began in early 2012. Between March and September 2012, the Department held a series of large public stakeholder meetings to inform the selection of a financing model. Four workgroups were established with the task of addressing specific issues related to the selection of a financing model and to examine: factors that should be present to promote "integration; roles that state and local government should perform; and recommendations on potential measures for evaluation of the integrated system.

Meeting announcements, materials and resource information were distributed. Webinars of the meetings and other discussions were utilized.

Also, a workgroup on chronic health homes was convened to make a recommendation on a new "Health Home" service under the ACA, and make a recommendation on how the new service could be developed to support any integration model. The health home provision authorized by the ACA provides an opportunity to build a person-centered system of care whereby medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan. MHA collaborated with Maryland Medicaid on the implementation of a Chronic Health Home State Plan Amendment (SPA) which takes effect on October 1, 2013.

The Behavioral Health Integration (BHI) process is now in Phase 3 which will involve developing specifications for the new system. This includes the development of the Request for Proposal (RFP) to select an Administrative Services Organization (ASO) to administer the new MA financing model, as well as collaborative process with stakeholders to develop performance measures, shared savings models, quality and access to care standards and a financing approach that complements emerging clinical models of integration.

Additionally, the next steps in the BHI, involve the combining of the mental health and the substance abuse administrations into a behavioral health administration. This process is overseen by the DHMH Deputy Secretary of Behavioral Health and Disabilities. The behavioral health administration organizational process is well underway with the recent appointment of a clinical director for mental health and substance abuse and the merger of the forensic services of three administrations (MHA, ADAA and Developmental Disabilities Administration [DDA]). In the process of blending the administrations, the Department has supported efforts to maintain the strengths and characteristics of each administration that are unique and serve to expedite and support many current initiatives.

**Strategy Accomplishment:**

This strategy was achieved.

(2-5B)

In collaboration with the DHMH Office of Medical Care Programs, identify specified programmatic changes needed to increase Maryland's eligibility for Medicaid's Balancing Incentive (Payments) Program (BIP) to increase shifts in state Medicaid spending towards community-based care.

Indicators:

- Development of a core standardized assessment instrument for all mental health services
- Participation on Maryland Access Point (MAP) Advisory Board and Money Follows the Person (MFP)/BIP workgroup meetings
- Analysis of programs, contracts, and regulations to identify conflicts in case management systems
- Addition of a statewide toll-free phone number and Web site to its MAP system of Aging and Disability Resource Centers (ADRC)

Involved Parties: Melissa Schober, MHA Medicaid Policy Analyst; MHA Office of Adult Services; DHMH Medical Care Programs (Medicaid); CSAs; MAP ADRCs; Traumatic Brain Injury (TBI) Resource Coordinators

MHA Monitor: Melissa Schober, MHA Medicaid Policy Analyst

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA participates in a BIP Implementation workgroup including the MFP/BIP Stakeholder meetings and other ad hoc workgroups created to implement the structural changes to enhance community-based care funding process as required through BIP. This program is a multi-year project and much of the analysis of programs, contracts, and assessment tools are in process.

In FY 2013, MHA participated in a MOU workgroup with representatives from the Office of Health Services and Maryland Department of Aging (MDoA) to standardize working agreements at the local level between Maryland Access Point (MAP) sites and their behavioral health partners for the purpose of promoting "no wrong door" access to long term services and supports. MAP has implemented a Web site linking resources for adults with disabilities. Efforts are underway to individualize mental health resources. MHA and the Maryland Department of Disabilities (MDOD) have created a training plan for MAP to include Mental Health First Aid and brain injury trainings. These services will be provided by MHA in FY 2014.

**Strategy Accomplishment:**

This strategy was achieved.

<b>GOAL III. WORK COLLABORATIVELY TO REDUCE THE IMPACT OF VIOLENCE AND TRAUMA FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND OTHER SPECIAL NEEDS.</b>
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**Objective 3.1. MHA will protect and enhance the rights of individuals receiving services and promote the use of advance directives in the behavioral health system of care.**

(3-1A)

MHA's Office of Forensic Services (OFS), in collaboration with the Mental Health & Criminal Justice Partnership (MHCJP) and the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council, will continue to promote the development of services toward community re-entry to include diversion, housing, and case management for individuals with mental illnesses who encounter the criminal justice system.

Indicators:

- Participation in workgroup to identify and implement actions that increase access to services that facilitate successful community re-entry
- Increased capacity to exchange data between MHA and the corrections system
- Minutes of meetings (IFSC and MHCJP) provided

Involved Parties: Larry Fitch, Dick Ortega, and Debra Hammen, MHA Office of Forensic Services; Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; CSAs; MHJCP; the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

MHA Monitor: MHA Office of Forensic Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHCJP and IFSC are comprised of members from the judiciary, criminal justice system, clinicians, consumers, advocates, and providers of service. The collaboration provides for a robust discussion and analysis of the issues associated with promoting a service delivery system that is comprehensive for individuals with mental illness who have encountered the criminal justice system. MHA's Office of Forensic Services (OFS) staff participated in bi-monthly meetings of the MHCJP and in subcommittee meetings on training for law enforcement agencies as evidenced by minutes, as well as attendance sheets maintained and created for the committees.

MHCJP has also been monitoring the implementation of DataLink, which enables the sharing of public mental health system treatment information with detention centers. DataLink, established in Baltimore City, has expanded to Howard and Anne Arundel counties in FY 2013. A DataLink subcommittee has been developed to encourage new sites for the next expansion, develop public health outcomes, troubleshoot, and provide technical assistance to new and existing sites.

The Secretaries of DHMH and DPSCS created a special criminal justice team to examine: best practices for pre-trial coordination between community mental health and substance abuse; post trial assessments for care in the detention center; health information/data sharing; and new models for discharge for those being released from the Department of Corrections. This team is comprised of MHA's Office of Special Needs Populations, CSAs, ADAA, and representatives from DPSCS with MHA serving as the

team lead for DHMH. The team submitted and secured a Bureau of Justice Second Chance grant to develop a Reach-In Program. This Reach-In Program is fully underway with programs in place to serve approximately 75 offenders with moderate to high risk histories of chronic mental illness and substance use and/or dependence issues. A group of case managers and peer support specialists has been hired and is establishing or re-establishing community linkages. This collective will connect with offenders within four months prior to release to assess community needs and continue to provide services six months post-release.

Analyzing the needs of individuals with mental illness, who have encountered the criminal justice system, will assist in the provision of services offered through BHI and Health Care Reform.

**Strategy Accomplishment:**

This strategy was achieved.

(3-1B)

Provide training and technical assistance for MHA facility staff and community forensic evaluators regarding court orders for forensic mental health opinions in criminal and juvenile justice cases.

**Indicators:**

- Training provided on court evaluations and status reports
- Symposium held to include presentations on services, community correctional concerns, legal and liability issues, etc. to at least 200 DHMH-MHA facility staff, community providers, and other state agencies
- Technical assistance provided on services for individuals returning to the community

**Involved Parties:** Larry Fitch, Debra Hammen, and Dick Ortega - MHA Office of Forensic Services (OFS); Gayle Jordan-Randolph, MHA Office of the Clinical Director; Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; University of Maryland Training Center

**MHA Monitor:** MHA Office of Forensic Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The Office of Forensic Services (OFS) staff met on a number of occasions with MHA facilities' staff and community providers to disseminate information and offer TA regarding issues facing court-involved consumers.

Additionally, a three-day training was provided on December 4-7, 2012, for community evaluators who develop court-ordered forensic evaluations. Also in June 2013, training was provided to community providers by the Community Forensic After Care Program (CFAP) pertaining to the provision of services to individuals returning to the community. A total of 25 persons attended the training. Trainings offered by the OFS afforded staff, community providers, and other audience participants with opportunities to receive information on: services for justice-involved consumers in the community; community reintegration; laws effecting community evaluations; and the clinical issues that are required when completing a forensic evaluation. Approximately 250 individuals participated in the various training activities. Attendance sheets were created and maintained for training.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 3.2. Continue to work collaboratively with appropriate agencies to improve access to mental health services for children with behavioral disabilities and individuals of all ages with psychiatric disorders and co-existing conditions, including but not limited to: court and criminal justice involvement, deaf and hard of hearing, traumatic brain injury (TBI), homelessness, substance abuse, developmental disabilities, and victims of trauma.**

(3-2A)

Facilitate community placements, ensure access to somatic and mental health services, and monitor plans of care for consumers with traumatic brain injury (TBI) through the TBI waiver.

**Indicators:**

- Plans of care developed and monitored for approximately 60 TBI waiver participants
- Increased utilization of enhanced transitional case management to support program's expansion and increased enrollment
- Financial incentives identified to expand provider capacity
- Additional providers enrolled
- Eligible participants enrolled in Money Follows the Person (MFP) Project, enhanced federal match spent on initiatives that increase community capacity

**Involved Parties:** Stefani O'Dea and Nikisha Marion, MHA Office of Adult Services; Medical Assistance Division of Waiver Programs; Coordinators for Special Needs Populations in MHA facilities; CSAs; TBI Advisory Board; community providers  
**MHA Monitor:** Stefani O'Dea, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA is the lead agency in Maryland for current Traumatic Brain Injury (TBI) initiatives, which include a Home and Community-Based Services (HCBS) Waiver for individuals with TBI. In FY 2013, 65 individuals were served through this program. No additional providers were enrolled. Six individuals were newly enrolled, five of whom qualified for

the Money Follows the Person (MFP) Demonstration Project. Enhanced matching federal funds were collected on services and used for approved re-balancing initiatives that expand community capacity. These initiatives included a new contract with Brain Injury Association of Maryland to provide program education and application assistance to individuals applying for the TBI Waiver program as well as assisting Marylanders with accessing information about specialized brain injury resources and other long term services and supports. The other approved rebalancing initiative, implemented during this reporting period, was the creation of a full time trainer position. This position is responsible for providing training on brain injury related topics and person centered care planning to various community-based human service agencies. The biggest issue to impact waiver enrollment in FY 2013 was the closing of University of Maryland Specialty Hospital in July 2012. This has resulted in an overall decrease in TBI waiver enrollments. MHA has implemented outreach activities to ensure that individuals in need of TBI waiver services are able to access the program. Plans of care were developed and updated as needed for all waiver participants.

**Strategy Accomplishment:**

This strategy was achieved.

(3-2B)

Continue to support and be actively engaged in the Medicaid Money Follows the Person (MFP) Behavioral Health Workgroup.

**Indicators:**

- Recommendations identified for final report
- Consultation offered regarding strengthened behavioral health services and supports for MFP waiver participants
- Consultation offered regarding the transition to the community process for Money Follows the Person (MFP) individuals with behavioral health needs
- Identification of elements of training needed by staff working with individuals involved in the transition process

**Involved Parties:** Marge Mulcare and Stefani O'Dea, MHA Office of Adult Services; DHMH Medical Care Programs (Medicaid); MHAMD; MDOD; Maryland Partnership for Affordable Housing (MPAH)

**MHA Monitor:** Steve Reeder, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The MFP Behavioral Health Workgroup, led by the Mental Health Association of Maryland (MHAMD), met to examine behavioral health services/supports and develop recommendations to enhance training for staff to facilitate the community transition process. The workgroup ended in FY 2013 and a final report was submitted by MHAMD to Maryland Medicaid.

Additionally, MHA participated on a steering committee – Maryland Partnership for Affordable Housing (MPAH) Advisory Group – chaired by MDOD and MFP representatives, to implement the changes within the federal Housing and Urban Development (HUD) 811 program in preparation for the HUD Notice of Funds Availability (NOFA), which are posted throughout the year for HUD projects. MHA also works with Maryland's Medical Assistance program on state plan amendments and issues such as MFP.

**Strategy Accomplishment:**

This strategy was achieved.

(3-2C)

MHA's Office of Special Needs Populations, in collaboration with Alcohol and Drug Abuse Administration (ADAA), Developmental Disabilities Administration (DDA), CSAs, advocates, and other involved parties will redesign the process for providing interpreting services, data collection, and the delivery of services using integrated, statewide, and regional approaches.

**Indicators:**

- Identification of uniform data tool to be utilized by CSAs in local jurisdictions
- Use of appropriate data tools by the Administrative Services Organization (ASO) - ValueOptions®Maryland - to track specific services rendered to individuals who are deaf or hard of hearing
- In collaboration with ADAA, an interpreting contract developed and utilized across populations and with individuals with co-occurring disorders
- Resources identified to develop regional teams to manage needs/services for individuals who are deaf or hard of hearing across the life span, on the local level

**Involved Parties:** Marian Bland, MHA's Office of Special Needs Populations; DHMH's Office of Behavioral Health and Disabilities; Iris Reeves, MHA Office of Planning and Training; MHA Office of Child and Adolescent Services; CSAs; Governor's Office of the Deaf and Hard of Hearing (ODHH); ADAA; DDA; ValueOptions®Maryland; consumers and family groups; providers; state and local agencies; colleges and universities; local service providers; advocacy organizations; consultants

**MHA Monitor:** Marian Bland, MHA Office of Special Needs Populations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA's Office of Special Needs Populations developed a uniform quarterly reporting form that was implemented locally on July 1, 2012 to collect information from providers on: the number of consumers receiving interpreting services to access public mental health system (PMHS) services; the type of interpreting; and type of being rendered. MHA will continue to work with ValueOptions®Maryland (VO) to collect data on those served through the PMHS. VO has added a new data field for providers to enter data on Axis III medical information regarding whether a person is deaf or hard of hearing. VO will be able to provide data to MHA on the number of persons receiving services in the PMHS, but only if all providers are entering this data. At this time, numbers served can be extracted from the CSA quarterly reporting forms.

There were plans to develop, in collaboration with ADAA, an interpreting contract to standardize the terms and eligibility requirements of this service delivery. However, this activity has been deferred because the Department of Budget Management (DBM) recently issued a RFP for an interpreting contract to serve all state agencies. The Department will have an option to participate in the state's contract with DBM once the process is finalized.

The Behavioral Health subcommittee of the Maryland Advisory Council on Deaf and Hard of Hearing and Deaf-blind has not been meeting during this reporting period. However members have made suggestions and provided input to assist with shaping services for individuals who are deaf or hard of hearing through the DHMH behavioral health integration (BHI) process. The subcommittee members explored the possibility of using Health Homes to develop regional teams; however, this option was not feasible at this time.

Additionally, several trainings were held locally and regionally to focus on deaf and hard of hearing issues, cultural sensitivity, and awareness issues. In March 2013, MHA's Office of Special Needs Populations and MHA's Office of Consumer Affairs sponsored a consumer and an advocate to attend a conference in Florida to obtain information from other states on best practices in serving individuals who are deaf or hard of hearing.

MHA continues to provide information on the department's BHI implementation and have encouraged involvement from the deaf community and advocates.

**Strategy Accomplishment:**

This strategy was achieved.

(3-2D)

MHA's Office of Special Needs Populations and MHA's Office of Consumer Affairs, in collaboration with MHA state facilities, will integrate trauma-specific education models and trauma-informed care principles and practices to sensitize facility clinical staff to advance effective treatment planning.

**Indicators:**

- Facilities staff trained on trauma-informed care principles and practices
- Senate Bill (SB) 556/House Bill (HB) 1150 Advisory Committee convened to identify recommendations to increase safety standards at MHA state facilities

**Involved Parties:** Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; Susan Kadis, MHA Office of Consumer Affairs; Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; SB 556/HB 1150 Advisory Committee; clinicians; facility staff; Maryland Disability Law Center (MDLC); DHMH

**MHA Monitor:** Marian Bland and Darren McGregor, MHA Office of Special Needs Populations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In July of FY 2011, an advisory committee was formed to implement SB 556/HB 1150 written to develop and implement strategies to promote the principles of trauma-informed care. One strategy included providing training in trauma-informed care principles as well as trauma specific services for staff and consumers within state-operated psychiatric hospitals. These facilities identified key staff to attend workshops on trauma with the goal of creating similar workshops to their internal curricula.

An independent consultant was also retained to interview each facility to better understand the process of progression toward operating as a trauma informed care facility. The consultant completed a report "Prevention, Detection, Response, and Monitoring Sexual Violence in Maryland State Facilities" which reported identified strengths and challenges with respect to training recommendations for staff and



consumers as well as evidence of trauma-informed care principles in MHA facility policy. The consultant recommended workshops on sexual assault/ sexual harassment prevention. In addition to training, policies were revised to create uniform response and report procedures with regard to sexual assault and harassment.

At the close of Calendar Year 2012, the SB 556/HB 1150 Advisory Committee furnished a full report identifying the facilities' progress in meeting the deliverables. Also, MHA's Office of Special Needs Populations gave testimony on the progress being made by facilities to meet these requirements. As of June 30, 2013, all state psychiatric facilities continue to participate in trauma-informed planning committees to review policy and train staff on trauma-informed care principles and practices. Key staff from each facility has attended a workshop on trauma-informed care principles as well as on the state's trauma specific model T.A.M.A.R. (Trauma, Addictions, Mental Health, and Recovery).

The bill also included launching a pilot program of a single gender unit to provide a greater sense of comfort and safety for women who did not wish to share a unit with men. This unit was launched in March of 2012 on the Eastern Shore Hospital Center. Nineteen women resided on this unit and reported, a year later (and continue to report), an increased feeling of safety. Outcome of discussions with the women generated goals, such as, learning about trauma education, having more group discussions, and moving to Stepping Stones, a transitional unit focused on independent living. Some of the women suggested that the group discussions include topics, such as, medication management, interacting with others who have a mental illness, nutrition/diet, and first aid. The group also requested having peer specialists co-lead groups.

Maryland facilities continue to research trauma treatment models such as Seeking Safety, Trauma Adaptive Recovery Group Education and Therapy (TARGET), and the Trauma Recovery and Empowerment Model (TREM) [a manualized group intervention designed for women trauma survivors with severe psychiatric disorders]. Also, these efforts contributed to the reduction of the utilization of seclusion and restraint as reported by the facilities. Additionally, facilities report that trauma-informed care training is incorporated in orientation for newly hired individuals. Technical assistance on trauma related issues will continue to be offered to the state facilities as well as community providers.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 3.3. MHA, in collaboration with CSAs, consumer and family organizations, governmental agencies, the administrative services organization (ASO), and other stakeholders, will address issues concerning improvement in integration of community services.**

(3-3A)

*\*Federal Mental Health Block Grant*

Continue to monitor crisis response systems, diversion activities, and community aftercare services to increase the diversion of inpatient and detention center utilization by individuals with mental illnesses and co-occurring disorders.

Indicators:

- Stakeholder workgroups convened to refine service descriptions, curricula, certification processes (where applicable), and professional qualifications in regulations of residential and mobile crisis (as well as peer support and supported employment services)
- Workgroup recommendations used in working with Maryland Medicaid to make above services eligible for federal payment
- Number of uninsured individuals diverted from emergency departments, MHA facilities, other inpatient services, and detention centers
- Number of alternative services provided
- Reduction of emergency department requests for admission to state hospitals
- Service continuum plan developed

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Gayle Jordan-Randolph, MHA Office of the Clinical Director; Melissa Schober, MHA Medicaid Policy Analyst; MHA Office of Adult Services; MHA Facility CEOs; MHA Office of Forensic Services; MHA Office of CSA Liaison; MHA Office of Consumer Affairs; MHA Office of Administration and Finance; Maryland Medicaid; CSA directors in involved jurisdictions; other stakeholders

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA, in collaboration with CSAs, providers, and other stakeholders, has developed and implemented diversion activities and initiatives throughout Maryland for individuals with mental illnesses and co-occurring disorders. These efforts included support of crisis response systems, mobile crisis programs, hospital diversion, crisis beds, and assertive community treatment (ACT) services. The MHA and the CSAs in various jurisdictions partnered with law enforcement agencies to offer training for officers, other public safety officials, and community providers regarding the management of crises involving persons who appear to have a mental health disorder and who may or may not have committed an offense.

Based on special sample reporting received during FY 2013 from Montgomery, Anne Arundel, Harford counties and Baltimore City, the total number of calls made to crisis response systems was 83,649 the number of mobile crisis team face to face visits was 1,551; the number of individuals receiving in-home intervention was 837; and the number of individuals seen for urgent care visits was 7,597.

All Core Service Agencies have developed various diversion strategies such as: hiring community outreach workers, short-term aftercare case managers, care coordinators and increasing utilization of crisis intervention services; giving additional support to warmlines and other crisis response and resource helplines; further defining contracts for urgent care services; meeting and partnering with hospital staff/administration to discuss services and expand strategies for diversion and high cost users; and developing general release forms that allow open communication between providers and the hospitals.

Additionally, during the 2013 Legislative Session, the Governor issued a supplemental budget appropriation that established efforts to expand crisis response systems, crisis intervention, early intervention services, and Mental Health First Aid training.

Work continues with Maryland Medicaid to make specific services eligible for federal payment. MHA experienced delay in the development of the peer support certification process due to the prioritization of the DHMH's BHI process, as well as the retirement of staff in MHA who were key to the workgroups. During FY 2013, staff positions were filled and collaborative work with ADAA continued through a workgroup on peer certification to evaluate any existing addiction and/or mental health core curricula that might potentially be used towards Peer Recovery Support Specialist certification.

**Strategy Accomplishment:**

This strategy was achieved.

(3-3B)

*\*Federal Mental Health Block Grant*

In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medicaid (MA), complete the final implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services for at least 210 children and youth and their families.

**Indicators:**

- Number of Waiver providers enrolled, (including youth and family peer support providers)
- Number of youth enrolled
- Implementation of waiver quality assurance plan

**Involved Parties:** MHA Office of Child and Adolescent Services; Maryland Child and Adolescent Mental Health Institute; MA; CSAs; Care Management Entities (CMEs); Maryland Coalition of Families for Children's Mental Health (MCF); Maryland Association of Resources for Families and Youth (MARFY); Governor's Office for Children (GOC); the Children's Cabinet; Local Management Boards (LMBs)

**MHA Monitor:** Al Zachik, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA continued implementation of the Centers for Medicare and Medicaid (CMS) sponsored psychiatric residential treatment facility (PRTF) demonstration, which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services.

A renewal 1915(c) waiver was submitted to and approved by CMS to allow the demonstration project to finalize its activities. A series of site visits to all 30 waiver providers was required by CMS as a condition of renewal. The waiver closed to admissions on September 30 2012, and one year later, at the end of FY 2013, only 45 youth remain enrolled. The waiver will only be available for youth admitted prior to September 30, 2012 because of federal statutory limitations on the duration of the demonstration. The demonstration project will close on September 30, 2014.

The waiver is guided by a federally required Quality Assurance Plan which was implemented two years ago with discovery and plans of correction. It was updated and submitted in March 2013. A proposed submission of a 1915(i) state Medicaid plan amendment has been developed to redesign the program and the financing of CME Wraparound intervention. The amendment is currently in the public comment phase of the process. If approved by CMS, changes would expand the eligibility for CME enrollment and replace this program.

**Strategy Accomplishment:**

This strategy was achieved.

(3-3C)

*\*Federal Mental Health Block Grant*

In collaboration with Maryland Medicaid, review and amend Maryland's State Medicaid Plan to improve the delivery of community mental health services; once revised, submit amendments for approval to the Centers for Medicare and Medicaid Services (CMS).

**Indicators:**

- Service descriptions, curricula, and certification processes (where applicable) refined and/or developed
- Professional qualifications for supported employment, peer support, and residential and mobile crisis services refined and/or developed
- A 1915(i) state plan amendment drafted to include supported employment as a Medicaid-reimbursable services; peer support and crisis services submitted separately to accommodate further regulatory development
- The 1915(i) state plan amendment refined and submitted to CMS

**Involved Parties:** Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; Penelope Scrivens, MHA Office of Adult Services; MHA Office of CSA Liaison; MHA Office of Administration and Finance; Maryland Medicaid-Office of Health Services  
**MHA Monitor:** Melissa Schober, MHA Medicaid Policy Analyst

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In FY 2012 and during FY 2013, MHA has participated in the DHMH Behavioral Health Integration (BHI) process through various workgroups comprised of consumers, providers and other stakeholder groups as well as the DHMH Steering Committee to examine current services and to review recommendations that promote building upon the strengths in our existing systems. Maryland is currently in phase 3 of the BHI process and is moving forward with the Department's decision to implement a performance-based carve out of mental health and substance abuse services as well as merge the mental health and substance use administrations.

Activities included in the DHMH's Phase 3 include the development of Chronic Health Homes in Maryland. The health home provision authorized by the Affordable Care Act (ACA) provides an opportunity to build a person-centered system of care that achieves improved outcomes for recipients of state Medicaid programs. Health Homes aim to further the integration of behavioral and somatic care through improved coordination. MHA collaborated with Maryland Medicaid on the implementation of a Chronic Health Home State Plan Amendment (SPA) which takes effect on October 1, 2013. Additionally, as stated earlier, MHA collaborated with Medicaid and applied for a 1915(i) SPA to serve children, youth and families. The service mix proposed is similar to the initial 1915(c) Residential Treatment Center (RTC) waiver. In addition to the full range of Medicaid somatic and behavioral health benefits available to all eligible individuals, participants enrolled in the proposed 1915(i) SPA will have access to a number of additional specialized services if they meet the applicable medical necessity criteria.

Due to the implementation of the DHMH's BHI process, some efforts were postponed to allow further development of the Health Home and 1915(i) SPA processes. However, there has been continued discussion on the next steps for the implementation of activities related to peer support and certification process. In January, 2013, a workgroup on peer certification was re-convened in order to evaluate any existing addiction and/or mental health core curricula that might potentially be used towards a Peer Recovery Support Specialist certification. In FY 2014, Maryland will utilize the assistance of SAMHSA's *Bringing Recovery Supports to Scale Technical Assistance Center Strategy* (BRSS TACS) Policy Academy efforts to expand and strengthen the role of Peer Support Specialists and Recovery Support Specialists.

**Strategy Accomplishment:**

This strategy was achieved.

(3-3D)

In collaboration with Maryland Medicaid and the Alcohol and Drug Abuse Administration, review and revise the financing mechanisms to improve the delivery of integrated behavioral health care.

Indicators:

- Regular and routine agency participation in statewide discussions
- Regular and routine collaboration with stakeholders to ensure diverse viewpoints are represented
- Review and refine state regulations to foster integrated care delivery
- Where appropriate, draft amendments to the Medicaid State Plan

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; Penelope Scrivens, MHA Office of Adult Services; MHA Office of CSA Liaison; MHA Office of Administration and Finance; ADAA; Maryland Medicaid-Office of Health Services

MHA Monitor: Melissa Schober, MHA Medicaid Policy Analyst

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

As part of the FY 2012 budget, the Maryland General Assembly asked the DHMH, to convene a workgroup and provide recommendations “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues”. The Department established a planning team led by the Deputy Secretary of Health Care Financing. The process included a consultant’s report, followed by the Secretary’s development of seven principles of behavioral health integration and a series of stakeholders’ workgroups to inform the recommendations of a financing model.

Between March and September 2012, the Department held a series of large public stakeholder meetings. This phase involved a large steering committee and four workgroups were established with the task of addressing specific issues related to the selection of a financing model. The proposed models include: a protected carve-in of behavioral health services; a risk adjusted and/or performance-based carve-out of services; and a behavioral health organization response for those with serious mental illness or serious co-occurring disorders. After considering all input, on November 1, 2012, the Steering Committee issued a report recommending a specialty behavioral health carve-out model. The Steering Committee recommended that the carve-out operate using an administrative services organization (ASO), with significant and meaningful performance risk at the ASO and behavioral health provider levels.

MHA, ADAA, and Medicaid continued to convene meetings in June and July 2013. These meetings constituted Phase 3 of the behavioral health integration process, moving forward with DHMH’s decision to implement a performance-based carve out of mental health and substance use disorder services as well as the merger of the Mental Hygiene and Alcohol and Drug Abuse Administrations.

On June 4, June 20, and July 18, 2013, three large meetings were held for stakeholders to offer input on the upcoming request for proposals (RFPs) for the new performance-based ASO.

MHA participated in the stakeholder meetings and is currently actively participating in writing a new RFP for an ASO that will serve consumers and their families in a newly integrated system by administering the new MA financing model, as well as a collaborative process with stakeholders to develop performance measures, shared savings models, quality and access to care standards and a financing approach that complements emerging clinical models of integration.

**Strategy Accomplishment:**

This strategy was achieved.

(3-3E)

In collaboration with Maryland Medicaid and the Alcohol and Drug Abuse Administration (ADAA), respond to funding opportunities included in the Patient Protection and Affordable Care Act.

**Indicators:**

- Respond to the Medicaid Emergency Psychiatric Demonstration (MEPD) call for proposals (awarded March 13, 2012)
- Begin developing a health home model to serve people with serious and persistent mental illness (SPMI), substance abuse disorders, and/or co-occurring chronic somatic health conditions

**Involved Parties:** Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; MHA Office of Adult Services; MHA Office of CSA Liaison; MHA Office of Administration and Finance; ADAA; Maryland Medicaid-Office of Health Services

**MHA Monitor:** Melissa Schober, MHA Medicaid Policy Analyst

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Efforts to develop Chronic Health Homes (an approach to health care, consisting of a team of health care professionals that provide integrated health care and linkages to long-term community care services and supports) continued throughout FY 2013.

Health Homes were included as part of the health reform section under the Affordable Care Act (ACA) and this service is designed to prevent unnecessary hospitalizations and emergency department usage, while improving the coordination of whole-person (somatic and behavioral) health care. One hundred and twenty-five psychiatric rehabilitation, opioid treatment, and mobile treatment providers attended a half-day training session on July 9, 2013. Six Webinars for specific providers, including: those that serve children and adolescents; psychiatric rehabilitation programs; opioid treatment providers; as well as a Webinar on accreditation, were provided in August and September 2013. MHA, ADAA, and Medicaid worked diligently on the Chronic Health Home State Plan Amendment which takes effect October 1, 2013.

Additionally, in October 2011, MHA (in conjunction with the State Medicaid Agency) submitted a successful application and was awarded funding for the Medicaid Emergency Psychiatric Demonstration Project (MEPD), established under the ACA. Maryland will be one of 11 states along with the District of Columbia to participate to test whether Medicaid beneficiaries who are experiencing a psychiatric emergency get more immediate, appropriate care when institutions for mental diseases receive Medicaid reimbursement. The MEPD demo is proceeding and MHA has successfully submitted data for each quarter beginning July 1, 2012.

**Strategy Accomplishment:**

This strategy was achieved.

(3-3F)

*\*Federal Mental Health Block Grant*

MHA's Office of Special Needs Populations will coordinate with DHMH's effort to provide more information about services and outcomes to local detention centers by utilizing ADAA's Screening, Brief Intervention, Referral, and Treatment (SBIRT) tool.

**Indicators:**

- Utilization of experiences questionnaire as the standard tool for all practices across systems and agencies (emergency rooms, military, criminal justice, child-serving systems, etc.)
- Technical assistance, general public education, and social marketing (including consumers, general assembly, etc.) provided on trauma to ensure culturally competent, trauma-informed systems and better coordinated service systems (ex: pre-trial evaluation pilot)
- Identification of Evidence-Based Practices (EBPs) – science-informed practices with proven outcomes – and workforce enhancement needs to address identified gaps.
- Necessary regulatory changes determined and financing strategies developed including federal funding opportunities (grants, MA, health care reform) and cross-system duplication to fund gaps in trauma-focused intervention and treatment.

**Involved Parties:** Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; MHA Office of Consumer Affairs; ADAA; DDA; community health centers; mental health clinicians; advocacy groups

**MHA Monitor:** Darren McGregor, MHA Office of Special Needs Populations



**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA continues to monitor use of screening tools in programs funded through the Administration in programs such as Maryland's Trauma, Addictions, Mental Health, And Recovery (TAMAR) project, a program which provides treatment for incarcerated men and women who have histories of trauma and mental illnesses. ADAA's Screening, Brief Intervention, Referral, and Treatment (SBIRT) tool is not currently used within the local detention centers under the auspices of MHA. Programs in Maryland's correctional facilities; however, use a variety of assessment tools including the Adverse Childhood Experiences (ACE) and the Brief Jail Mental Health Survey, utilized by independent mental health providers approved by the CSAs, to assess individuals in the correctional system. Also, per Core Service Agencies/vendor contract agreements, each local vendor/provider utilizes screening and assessment tools approved by the CSA for that jurisdiction. MHA requires each jurisdiction to submit a standardized utilization and demographic report four times per year. All modifications to the contract agreements or conditions of awards (COAs) for jail funded programs are required to be submitted to MHA. Continued progress towards DHMH's Behavioral Health Integration process may support future training and implementation of SBIRT from ADAA.

MHA has identified evidence-based and best practice models to be effective with consumers with trauma histories such as Seeking Safety, Motivational Interviewing, and the Trauma Recovery and Empowerment Model (TREM) [a manualized group intervention designed for women trauma survivors with severe psychiatric disorders]. Additionally, TAMAR is moving toward becoming an evidence-based practice. Also, MHA distributes a manual on trauma-informed care to all TAMAR training participants with the understanding that technical assistance will be provided as needed. At the end of FY 2013, pre and post evaluations of each TAMAR module will be developed in cooperation with a University of Baltimore doctoral student.

The MHA Office of Special Needs Populations provides technical assistance and education to other agencies, organizations and the general public upon request. In FY 2013, MHA presented workshops on trauma-informed care to the Social Work conference and to "Tic Talk" of Baltimore County. Eighty people participated in these sessions.

In July of FY 2011, an advisory committee was formed to implement Senate Bill 556/House Bill 1150 that was written to promote the principles of trauma-informed care. Strategies were developed and implemented to provide training in trauma-informed care principles as well as trauma specific services for staff and consumers within state-operated facilities. Facilities identified key staff to attend workshops on trauma with the goal of creating similar workshops to their internal curricula. The trauma specific training included the ACE trauma screening tool. A consultant was retained to recommend workshops on sexual assault/ sexual harassment prevention. In addition to training, policies were revised to create uniform response and report procedures with regard to sexual assault and harassment to the state-designated protection and advocacy system.

**Strategy Accomplishment:**

This strategy was achieved.

(3-3G)

MHA, in collaboration with the MHA facility CEOs, CSAs, and providers, will convene a workgroup to identify the needs of patients ready for discharge and community integration.

Indicators:

- Workgroup convened
- Recommendations for a service continuum plan developed

Involved Parties: Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; MHA Office of Adult Services; Lissa Abrams, consultant; CSAs; facility CEOs; providers; other stakeholders

MHA Monitor: Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

All facilities report Length of Stay data monthly to MHA Executive Director and MHA Deputy Director with progress and strategies for each individual patient.

A special task group has been convened with the former Director of MHA Adult services to address the community issues that prevent discharge for our long term patients. Initially the primary focus will be the patients of the Spring Grove Hospital Center (SGHC). The committee was convened to develop new community services tailored to the needs of individuals hospitalized primarily at SGHC. The Committee included representatives from; Community Behavioral Health Association of Maryland (CBH); MHAMD; NAMI MD; OOOMD; Maryland Association of Core Service Agencies (MACSA); and SGHC. The Committee met approximately six times. As a result of the discussion, several recommendations were implemented as the project progressed.

Fifteen recommendations were hospital-related which included: increased communication of names of discharges going directly to the CSAs; increased use of the Consumer Quality Team (CQT), peer support; resolution of financial issues; and on-site monthly orientations and other means of preparing patients, such as increased responsibilities on campus, in preparation for discharge. Thirteen MHA-related recommendations included: encouragement of improved process of Medicaid enrollment; survey/data collection; streamline referral process to include multi-jurisdictional options, availability of wraparound and other types of funding; services for individuals in need of medication administration; and increased number of housing subsidies. Six community-related recommendations included: increased number of trained WRAP facilitators; additional flexible supports; in-reach and early engagement prior to discharge; follow-up on CQT interview results; prioritization of patients for psychiatrist appointments within one week of discharge; and increased peer support after discharge.

As part of the discharge planning process, the CQT interviewed patients at SGHC to inquire about their preferences for discharge services and community support. This information proved invaluable in helping providers and hospital staff support the consumer's preference. Interview results were made available in the medical charts.

SGHC's catchment area includes Harford, Baltimore, Anne Arundel, Prince George's counties and Baltimore City. The CSAs from these jurisdictions agreed to develop services for patients identified by the hospital and regional services are being contracted with community providers. Many services are in place since MHA planned for the funds to be awarded and services developed in FY 2013. A variety of services and supports were recommended, based on an identified general need of SGHC patients, such as: expansion of assertive community treatment (ACT) team service capacity; increased housing and residential rehabilitation program (RRP) beds; and upgrading RRP beds from general to intensive status. In FY 2013, the project identified 73 eligible patients and 17 were discharged as a direct result.

**GOAL IV. PROVIDE A COORDINATED APPROACH TO INCREASE EMPLOYMENT AND PROMOTE INTEGRATION OF SERVICES AND TRAINING TO DEVELOP AND SUSTAIN AN EFFECTIVE BEHAVIORAL HEALTH WORKFORCE.**

**Objective 4.1. MHA, in collaboration with CSAs and state agencies, will develop employment options and supports to increase the number of consumers employed.**

(4-1A)

*\*Federal Mental Health Block Grant*

Continue to implement the Maryland Mental Health Employment Network (MMHEN), a consortium of Maryland mental health supported employment providers and CSAs, to increase and enhance the array of choices of supported employment services available by utilizing Social Security Administration incentives such as Ticket-to-Work.

Indicators:

- Continued administrative infrastructure and operation of MMHEN at Harford County Office on Mental Health (the Core Service Agency)
- Data reported on number of programs participating and consumers receiving training in these programs
- Number of consumers receiving individual benefits counseling in the Ticket-to-Work Program

Involved Parties: Steve Reeder, MHA Office of Adult Services; Maryland Department of Disabilities (MDOD); Work Incentives Planning and Assistance (WIPA) Project; University of Maryland Evidence-Based Practice Center (UMD EBPC); Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ValueOptions@Maryland; SSA; consumers,

MHA Monitor: Steve Reeder, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The Maryland Mental Health Employment Network (MMHEN) is now in its fourth year of implementation. MMHEN was developed as an employment network with an administrative model, to help the Social Security Administration (SSA) disability beneficiaries with serious mental illness to obtain and retain employment, while developing a career path that would lead to economic and personal self-sufficiency. MHA, in collaboration with SSA, Maryland State Department of Education-Division of Rehabilitation Services (MSDE-DORS), the Harford County Core Service Agency (CSA), and the evidenced-based supported employment providers, continued this demonstration project under the auspices of SSA's Ticket-to-Work regulations. MMHEN staff perform assignment and payment requirements of the Ticket program while allowing participating evidence-based supported employment (EB-SE) providers to focus on service delivery to consumers. The participating providers are Alliance (Belcamp), Goodwill STEP (Baltimore and Westminster), Mosaic (Timonium), Humanim (Columbia), and Cornerstone Montgomery (formerly St. Luke's House). Their participation in the Ticket-to-Work program also generates a new stream of funding for these providers.

In FY 2013, 179 individuals participated in the Ticket to Work program through this employment network and MMHEN collected \$88,407, an increase of 89% from FY 2012. Services received included job placement, benefit counseling, wage tracking and job coaching, as needed. Additionally, MMHEN partners with OOOMD to provide peer supports to consumers involved with EB-SE providers. MMHEN has also expanded its ability to provide personalized benefits counseling to ticket holders who are not affiliated with supported employment programs. In FY 2013, MMHEN facilitated and provided seven one-day training programs, about Social Security work incentives and safety nets, to 280 employment specialists, ACT team staff, consumers, and family members.

MHA has worked closely with Cornerstone Montgomery, a high volume network member, to identify consumers who can benefit from intensive benefits counseling with the support of an on-site benefits counselor and an On Our Own of Maryland representative. In FY 2013, a total of 45 individuals participated in this intensive benefits counseling project.

In FY 2013, the MMHEN developed a process manual that documents all procedures, data reporting, wages trends and outcomes. MMHEN also developed electronic and printed outreach materials. MMHEN is exploring other ways to expand ticket assignments, including selecting agencies that hire people with disabilities in business services contracts as well as reaching out to individuals who require only benefits counseling in order to be successfully employed.

**Strategy Accomplishment:**

This strategy was achieved.

(4-1B)

MHA, in collaboration with NAMI MD and the University of Maryland Evidence-Based Practice Center (UMD EBPC), will continue implementation of the Johnson & Johnson - Dartmouth Community Mental Health Program Family Advocacy Project to educate family members as to the role of supported employment in consumer recovery.

**Indicators:**

- Increased understanding of MHA's supported employment program by consumers, transition-age youth, and families
- SE resource person trained and available at selected local NAMI affiliates – Metro Baltimore, Frederick, Howard, and Montgomery county organizations
- Incorporation of supported employment content for Family-to-Family classes available to selected NAMI affiliates

**Involved Parties:** Steve Reeder, MHA Office of Adult Services; MHA Office of Planning and Training; Maryland Department of Disabilities (MDOD); University of Maryland Evidence-Based Practice Center (UMD EBPC); Dartmouth Psychiatric Research Center; Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ValueOptions@Maryland

**MHA Monitor:** Steve Reeder, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The Family Advocacy Team is a special project within the Johnson & Johnson-Dartmouth Community Mental Health Program whose mission is to develop a collaborative working relationship between a state's mental health authority and the state's NAMI chapter to educate families about the important connection between employment and recovery. In Maryland, this was accomplished through three Benefits Counseling Workshops held on January 18, March 23, and June 1, 2013. MHA provided support for the two benefits experts, both of whom are Community Work Incentive Coordinators (CWICs), to provide oral and written materials to attendees of all three six-hour Benefit Counseling workshops. The two CWICs conducted these Benefits Counseling Trainings for a total of 50 providers and 85 consumers/family members.

NAMI staff and/or board members from Metro Baltimore, Howard, Frederick and Montgomery Counties attended at least one Benefits Workshop. Prince George's NAMI president and board members attended the June Benefits Workshop and are knowledgeable about Evidence Based Practice EB-SE. The Johnson & Johnson-Dartmouth Community Mental Health Program Family Advocacy Project Team Leader, NAMI MD and Mental Hygiene Administration worked collaboratively to elicit interest from NAMI members and provider agencies in the Benefits Workshops and the important role employment has in recovery. The Family Advocacy Team Leader will continue to speak directly with other Affiliate Presidents, or Board members, regarding the importance of employment in recovery and encourage them to send at least one Board member to future Benefits Counseling Workshops.

On January 30, 2013, forty EB-SE program supervisors and staff members participated in a six-hour interactive workshop, "Employment and Families," designed to help providers understand the family's perspective on mental illness and employment. A power point presentation was developed for this workshop, along with a White Paper developed in conjunction with the Community Behavioral Health (CBH) Vocational Committee, discussing what employment specialists and families can expect from each other. The document was distributed to all workshop attendees and to CBH members. Also, NAMI National's new edition of its Family-to-Family curricula (a support education program that offers unique, experiential learning programs for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery), which all states must follow, includes information developed by Maryland's Family Advocacy Team, in conjunction with CBH's Vocational Committee, on what families need to know about EB-SE.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 4.2. MHA will develop and implement collaborative training initiatives involving other agencies and stakeholders serving individuals with psychiatric and co-occurring disorders in the behavioral health system of care.**

(4-2A)

Continue to enhance workforce development by expanding the involvement of Peer Employment Resource Specialists (PERS).

Indicators:

- Peers involved in disseminating person centered care planning to consumers
- PERS to be utilized throughout the state to give updated workforce development strategies to peer run groups and other stakeholders
- Behavioral Health Peer Support workgroup convened with ADAA to explore training initiatives for integrated peer support in Wellness & Recovery Centers (WRCs)
- Use of Network of Care Web site to identify workforce development issues and career opportunities

Involved parties: James Chambers, MHA Office of Adult Services; MHA Office of Consumer Affairs; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; OOOMD; CBH; WRCs; ADAA Regional Services Manager; mental health advocacy groups; peer organizations

MHA Monitor: James Chambers, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

During the implementation of the Mental Health Transformation-States Incentive Grant (MHT-SIG), efforts were fostered to promote workforce development and peer employment training. Through the MHT-SIG, the Johns Hopkins-Sar Levitan Center partnered with the Maryland Department of Labor, Licensing and Regulation (DLLR) to focus on mental health workforce and workplace development issues. The Sar Levitan Center worked with a broad range of stakeholders, boards, as well as community colleges throughout the state. One project initiated by the Sar Levitan Center was the Workforce Pipelines initiative which, in effect, established in Anne Arundel and Baltimore counties, a certificate program for direct care workers in the Public Mental Health System (PMHS). The certificate program in turn led to the next steps, for eligible individuals entering an Associate of Arts (AA) degree program in behavioral health with community college tuition rates being subsidized for the cost of the training. This program not only improved the quality of mental health programs by facilitating higher paid positions that recruit more competitively, but also provided a source of opportunities for steady employment as well as educational advancement for consumers interested in working in the field of mental health.

The Peer Employment Resource Specialist (PERS) training was facilitated throughout the state and to date there have been more than 86 consumers who have graduated from the PERS program. In the summer of FY 2012, follow-up PERS training sessions, specifically for PERS Graduates, were conducted on topics of employability Development Planning and on how to engage employers. The program ended in September 2011. However, a *Toolkit for Peer Employment and Resource Specialists* (PERS) training manual was developed and distributed upon request through MHA to further the training of peer employment.

In January, 2013, a work group on peer certification was reconvened in order to evaluate any existing addiction and/or mental health core curricula that might potentially be used towards a Peer Recovery Support Specialist certification. Additionally, MHA established linkage with ADAA to have full representation from all consumers and staff with interest in mental health and substance abuse concerns. Two curricula were selected from among a broad range of core curricula for in-depth review: 1) the Connecticut Community for Addiction Recovery's (CCAR's) Coach Academy core training for Substance Use Disorder (SUD) Specialists and 2) a Mental Health corollary core curriculum - the Wellness Recovery Action Plan (WRAP) facilitators training. The group then worked on identifying other courses that would help bridge the deficit of the two core curricula. The final recommendations for curriculum and standards are to be presented to MHA leadership in FY 2014. Additionally, MHA and ADAA will convene A *Bringing Recovery Supports to Scale Technical Assistance Center Strategy* (BRSS TACS) Policy Academy designed to build workforce capacity and create infrastructure to ensure collaboration and sustainability for Peer Recovery Support Services.

Other efforts to increase peer employment resource development take place through the Maryland Consumer Volunteer Network, which has implemented activities to promote leadership skills and create workforce development initiatives throughout the system. Efforts have been underway to upgrade computer technology to facilitate access to a variety of programming opportunities including the use of Network of Care.

**Strategy Accomplishment:**

This strategy was achieved.

(4-2B)

*\*Federal Mental Health Block Grant*

Expand intensive skills-based training opportunities to include motivational interviewing and person centered care planning (PCCP), to increase the effectiveness of service delivery within the behavioral health system of care.

**Indicators:**

- Number of motivational interviewing trainings given to providers
- Number of PCCP trainings held for consumers and providers
- Number of participants trained in each of the above
- Pre/post test, anecdotal evidence of skill improvement

**Involved Parties:** University of Maryland Training and Evidence Based Practice Centers; Cynthia Petion and Carole Frank, MHA Office of Planning and Training; MHA Office of Adult Services; ValueOptions@Maryland; CSAs; providers; consumers; Consultants

**MHA Monitor:** Carole Frank, MHA Office of Planning and Training



**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA continues efforts to promote skill-based client-centered opportunities.

**Motivational Interviewing**

Motivational interviewing (MI) is a person-centered goal directed skill to enhance any counseling method or approach used by counselors or front-line staff to resolve ambivalence and strengthening the person's own motivation. Originally introduced for addiction services, MI training is designed to be presented on-site to organizations and agencies that provide services to individuals with behavioral health issues. More than 390 individuals participated in MI training sessions in 2013. Of that number, 366 were newly trained individuals and more than 30 individuals participated in three sets of coaching/refresher trainings. Encounter skill improvement, through the use of the MI approach, has been evident through class exercises, evaluations, and anecdotal reports. For four of the MI trainings mentioned above, results were scored using the Video Assessment of Simulated Encounters-Revised (VASE-R). Examinees wrote responses to simulated encounters that were scored against MI core standards. Resulting scores were 10-11 points higher on post tests, indicating a statistically significant understanding of the core standards as a result of the training.

**Person Centered Care Planning**

Person centered planning or person centered care planning (PCCP) is designed to enable people to direct their own plan for services and supports and is in concert with MHA's emphasis on a recovery-oriented system of care. In FY 2013, trainings in PCCP were facilitated for more than 275 individuals. These individuals included case managers, Health Department staff, supported employment providers, and individuals with co-occurring disorders. Additionally, in September 2012, national PCCP expert Diane Grieder, under contract with UMD EBPC and The Training Center, provided training on PCCP for the 25 attendees comprised of ACT and supported employment programs team leaders of the Supported Employment Supervisors' Academy.

Evaluations and comments indicated participants experienced an increased understanding of the core concepts of PCCP. Post training calls indicated significant progress in implementing PCCP. Some improvement was noted at all programs.

**Strategy Accomplishment:**

This strategy was achieved.

(4-2C)

*\*Federal Mental Health Block Grant*

MHA, in collaboration with DHMH, ADAA, and DDA, will convene a workgroup to develop an action plan for behavioral health workforce development.

Indicators:

- Workgroup progress notes of activities recorded
- Assessments conducted to determine workforce capacity
- Submission of results and recommendations regarding behavioral health workforce issues to the Governor's Taskforce on Workforce Development
- Use of data to track and evaluate key workforce issues
- Recruitment and retention issues addressed

Involved Parties: Carole Frank, MHA Office of Planning and Training; MHA Office of Child & Adolescent Services; DHMH State Program Administrator for Co-occurring Disorders; University of Maryland; ADAA; DDA; CSAs; providers; other stakeholders

MHA Monitor: Carole Frank, MHA Office of Planning and Training

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In August 2012, the DHMH Behavioral Health Workforce Development Committee was restructured to include the mental health and substance abuse key staff as co-chairs, as well as broaden the membership of representatives from consumer, provider, advocacy organizations and local mental health and substance abuse authorities. The first meeting was held on October 31, 2012. The group met to brainstorm on strategies that will address the provisions of an adequate workforce. The DHMH Deputy Secretary for Behavioral Health also advised the Committee to serve as a repository of information and resources. Meetings included roundtable discussions related to state, local and national Behavioral Health Workforce development efforts. In October 2013, efforts were implemented to align the workgroup with the Behavioral Health Integration process and training in co-occurring disorders (COD). The MHA/ADAA/DDA/COD Workforce has been established, focusing on: workforce development; assessing workforce needs to achieve competency in dual diagnosis capability (DDC); best training methodologies; existing resources, etc. Minutes are recorded from each meeting.

The Committee also reviewed the recommendations of the Governor's Taskforce on Workforce Development. Workgroup co-chairs will attend public meetings as appropriate and report during roundtable discussions. MHA continues to work collaboratively with ADAA under DHMH direction to develop co-occurring training resources for providers and clinicians across the lifespan.

**Strategy Accomplishment:**

This strategy was partially achieved.

(4-2D)

*\*Federal Mental Health Block Grant*

The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and Maryland State Department of Education (MSDE), will promote the use of developed curricula for training of staff in child mental health and education professions.

**Indicators:**

- Number of education and mental health professionals and providers completing training modules

**Involved Parties:** MHA Office of Child and Adolescent Services; MHA Office of Planning and Training; MSDE; the University of Maryland Schools of Medicine and Social Work; professional schools representing higher education; the Maryland Coalition of Families for Children's Mental Health; provider agencies; local school systems

**MHA Monitor:** Al Zachik, MHA Office of Child and Adolescent Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The Maryland Interdisciplinary Mental Health Workforce Committee, under the leadership of the MSDE Division of Special Education/Early Intervention Services and MHA developed a set of core competencies in child and adolescent mental health. These competencies are comprised of 10 modules, designed to provide baseline training to mental health professionals working with children and youth with mental health issues and their families, and include the following content areas:

1. Child Development
2. Youth and Families as Partners
3. Screening, Assessment, and Referrals
4. Treatment Planning and Service Provision
5. Outcomes and Quality Improvement
6. Behavior Management
7. Health and Safety
8. Community Development
9. Communication
10. Cultural and Linguistic Competence

Training on the core competencies will be implemented through the University of Maryland, School of Social Work Institute for Innovation and Implementation's on-line Training Center. This on-line training center is designed to be a centralized location for virtual training for individuals working within the child-serving system. In FY 2012, 387 individuals received certificates of completion. Data for FY 2013 is not yet available.

**Strategy Accomplishment:**

This strategy was achieved.

(4-2E)

Collaborate with Department of Public Safety and Correctional Services (DPSCS), the judiciary, law enforcement, CSAs, and community stakeholders to develop cross-educational events concerning mental health and substance use services for justice-involved individuals.

**Indicators:**

- Training for police upon request
- Collaboration on a cross-education event with parole and probation personnel and community mental health stakeholders
- Collaboration on a cross-education event with court personnel (judges, states' attorneys, public defenders, and clerks)

**Involved parties:** Richard Ortega, and Debra Hammen - MHA Office of Forensic Services; MHA Office of the Clinical Director; Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; ADAA; CSAs; Baltimore Police Academy, Key Point

**MHA Monitor:** Larry Fitch, MHA Office of Forensic Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In FY 2013, MHA, in collaboration with the Department of Public Safety and Correctional Services (DPSCS), the judiciary, law enforcement, CSAs, and community stakeholders, developed cross-educational events concerning mental health and substance abuse services for justice involved individuals. Twenty-three hours of Continuing Education was provided through DHMH Forensic Evaluator Training with 40 participants. Eighty-eight participants from various agencies received training and updated information on effective strategies to be utilized by law enforcement when responding to persons with mental illness and understanding clinical aspects of competency evaluations to include a discussion on malingering. Also, a lecture was presented on Sex Offender Registry with 22 participants.

The Secretaries of DHMH and DPSCS created a special criminal justice team to examine: best practices for pre-trial coordination between community mental health and substance abuse; post trial assessments for care in the detention center; health information/data sharing; and new models for discharge for those being released from the Department of Corrections. This team is comprised of MHA's Office of Special Needs Populations, CSAs, ADAA, and representatives from DPSCS with MHA serving as the team lead for DHMH. The team submitted and secured a Bureau of Justice Second Chance grant to develop a Reach-In Program. This Reach-In Program is fully underway with programs in place to serve approximately 75 offenders with moderate to high risk histories of chronic mental illness and substance use and/or dependence issues. A group of case managers and peer support specialists has been hired and is establishing or re-establishing community linkages. This collective will connect with offenders within four months prior to release to assess community needs and continue to provide services six months post-release.

**Strategy Accomplishment:**

This strategy was achieved.

(4-2F)

MHA, in collaboration with ADAA, will continue to participate in planning processes, trainings, and other activities that will enhance behavioral health integration efforts.

Indicators:

- Co-leadership of MHA and ADAA established to plan and facilitate MHA annual conference incorporating a behavioral health integration theme
- Information on trainings and cross trainings from each administration maintained on both ADAA and MHA Web sites
- Collaboration between MHA and ADAA to plan the kick-off celebration for National Recovery Month (September)
- Workgroup convened to explore the establishment of a combined behavioral health advisory council and submit recommendations to DHMH

Involved parties: Cynthia Petion and Carole Frank, MHA Office of Planning and Training; DHMH State Program Administrator for Co-occurring Disorders; ADAA Director, Office of Education and Training for Addiction Services (OETAS) and staff; ADAA Division Director, Recovery Oriented System of Care (ROSC); University of Maryland-Evidence Based Practice Center (UMD EBPC); BHSIC; Central East Addiction Technology Transfer Center; Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council; Maryland State Drug and Alcohol Abuse Council; CSAs; providers

MHA Monitor: Carole Frank, MHA Office of Planning and Training

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

A number of existing mental health treatment and rehabilitation programs, as well as programs established through ADAA, have developed dual diagnosis capability (DDC) and are able to offer substance abuse treatment services to individuals with mental illnesses.

The MHA Annual Conference Planning Committee was co-chaired by MHA Chief of Training and ADAA Director of the Office of Education and Training for Addiction Services (OETAS) with the theme of “Behavioral Health – Learning from Each Other”. To assist programs in assessing their capacity to provide integrated services for the co-occurring disorders population, the annual May conference included a workshop demonstrating empirically supported tools for use in assessing agency and provider DDC. More than 400 participants, representing multiple disciplines, attended the conference.

MHA, in collaboration with ADAA and DDA, completed the DHMH Supervisors’ Academies for Co-occurring Disorders in November of 2012. Approximately 40 supervisors/trainers from all three administrations participated in these final sessions. Additionally, in February, training authorities from both administrations participated in a planning session for Mid-Shore providers who had completed their internal Dual Diagnosis Capability Mental Health Treatment/Addiction Treatment assessments (DDCMHT/DDCAT). In the spring, the Central East Addiction Technology Treatment Center (CE ATTC) sponsored trainings for 93 Supported Employment supervisors on Motivational Interviewing and on supervising addiction and mental health peer mentors. In May, there was an Addiction workshop held for both administrations through OETAS. Twenty-five attended. MHA and ADAA also collaborated on the Recovery Day event through ADAA’s Special Assistant to the Director and MHA’s Chief of Training.

Both ADAA and MHA feature each others' trainings on their respective Web sites. DDA trainings are also included. A workgroup has been convened and is formulating recommendations to facilitate advancement of the DHMH Behavioral Health Integration process.

The Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council (Joint Council) and the State Drug and Alcohol Abuse Council (SDAAC) each chose representatives to form a Behavioral Health Council Workgroup with the purpose of developing a combined Behavioral Health Council model to present to both councils. The workgroup met several times and received TA through the Advocates for Human Potential, a contractor for SAMHSA's Center for Mental Health Services on specific related goals. The Workgroup has continued to meet over the past several months. Discussion has focused on, but not been limited to, the inclusion of county advisory councils as important components of the current system and the desire to maintain their involvement in the planning process, as well as consideration of establishing a supportive committee structure that would address themes to assist the progress of the new council in addressing key areas. Efforts continue with expectations that recommendations toward a combined council will be made in FY 2014-15.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 4.3. Develop initiatives that promote the delivery of culturally competent and linguistically appropriate behavioral health services.**

(4-3A)

MHA, in collaboration with key stakeholders, will refine the development and implementation of cultural competence training activities for consumers, providers, staff, and individuals in an integrated behavioral health system.

Indicators:

- Utilization of the cultural competence assessment tool to enhance further development of the Cultural Linguistic Competence Training Initiative (CLCTI) curricula
- CLCTI training modified to include behavioral health cultural and linguistic issues with additional emphasis, where appropriate, on regional and geographic differences
- Incorporation of cultural sensitivity awareness in training activities for special needs populations i.e. deaf and hard of hearing, Traumatic Brain Injury (TBI), lesbian, gay, bi-sexual, transgender, questioning (LGBTQ), individuals who are homeless, and individuals with co-occurring disorders
- Incorporation of cultural competence training efforts in state, federal, and local planning activities
- Exploration of the development of a cultural competence training project, in collaboration with ADAA

Involved Parties: Iris Reeves, MHA Office of Planning and Training; Marian Bland, MHA Office of Special Needs Populations; MHA Office of Consumer Affairs; other MHA staff; ADAA; CSAs; Maryland Advisory Council on Mental Hygiene/ Cultural and Linguistic Competence Advisory Committee (CCAC); consumers; family members; advocacy groups (CBH, OOOMD, NAMI MD MHAMD, the National Council on Alcoholism and Drug Dependency [NCADD])

MHA Monitor: Iris Reeves, MHA Office of Planning and Training

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Efforts to promote cultural competence and meet the needs of an increasingly diverse population continue to be important components of Maryland's mental health system of care.

The Cultural and Linguistic Competency Training Initiative (CLCTI) has provided training and consultation to adult programs and providers to promote program changes that would increase the cultural competency of the program and its recovery-orientation as well as reflect regional/geographic need, as appropriate. The cultural competence assessment tool (CCAT) was utilized to inform adjustments/modifications, where appropriate, in CLCTI curricula.

In December 2012, as a means of exploring the possibilities of a joint competence training project with ADAA, planning and implementation of an initial behavioral health dialogue between MHA and ADAA, *Behavioral Health Dialogue: “A Cultural Overview – The MHA & The ADAA*, took place. The session specifically focused on a cultural and historical overview of the two administrations. This all-day dialogue was attended by approximately 35 individuals who included management staff, mid-level managers, consumer representatives of advocacy organizations of MHA/ADAA, and peer specialists from Wellness and Recovery Centers. As the group explored similarities and differences, it was decided that a second session, focusing on language, would take place in FY 2014. There is much work to be done in this area as the modification of dialogue toward the more specific focus on development and implementation of cultural competence training in a behavioral health system is only gradually unfolding.

Collaborative training partnerships in the areas of CLCTI curricula have been formed and made available, as appropriate, for special populations. In FY 2012, a modified training model was developed to be utilized with small regional groups, special needs populations and geographically different groups. Since the inception of the CLCTI Project, more than 550 individuals have received, at a minimum, this modified 2-3 hour CLCTI training. MHA consults with the Governor’s Office of Deaf or Hard of Hearing (ODHH) on resources to address consumer and/or system related issues. MHA’s Office of Special Needs Populations held a one-day conference in which a workshop on access to innovative services was presented.

Technical assistance to assist provider agencies who wish to conduct LGBTQ support groups, is available upon request from MHA and the resources of the LGBTQ organizations and churches that have services and activities inclusive of all sexual orientations. Hearts and Ears, a LGBTQ Wellness & Recovery Center in Baltimore City, offers outreach sessions as requested.

FY 2015 Core Service Agencies (CSA) Plans for all jurisdictions were reviewed as they planned and managed efforts in the local mental health communities. Comments and technical assistance were offered on cultural competence activities upon request. MHA promoted local planning efforts by the CSAs to include the development of increased awareness of activities related to behavioral health integration and the need to incorporate strategies/activities on cultural competency in local annual plans. Additionally, the MHA Coordinator of Multi-Cultural Issues participated in MHA/ADAA Annual Conference planning and gave input to state planning documents.

**Strategy Accomplishment:**

This strategy was achieved.



**GOAL V. BUILD PARTNERSHIPS TO INCREASE THE PROVISION OF AFFORDABLE HOUSING AND REDUCE BARRIERS TO ACCESS IN ORDER TO PREVENT HOMELESSNESS FOR INDIVIDUALS WITH MENTAL ILLNESS.**

**Objective 5.1. Evaluate and develop opportunities to maximize current resources to promote affordable safe housing for individuals with serious mental illness.**

(5-1A)

Continue to work with other state and local funding resources to promote and leverage DHMH's Administration-Sponsored Capital Program grant (Community Bond) funding to support an array of affordable and integrated housing choices for individuals with serious mental illness (SMI).

Indicators:

- Community bond housing applications approved to increase funding for supported and independent housing units
- Pre-application meetings held to inform perspective applicants about the Community Bond Program and to encourage partnerships within the state and local areas to pursue development efforts
- Continued partnership with the Maryland Department of Housing and Community Development (DHCD), other state and local agencies, and funding entities to encourage participation in annual community bond proposal
- Program monitored, data collected and reviewed on number of units developed and persons served through the Community Bond Program
- Documentation of annual progress and barriers in the development and completion of housing projects

Involved Parties: Penny Scrivens, MHA Office of Adult Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Robin Poponne, MHA Office of Planning and Training; Marian Bland, MHA Office of Special Needs Populations; DHMH Office of Capital Planning, Budgeting, and Engineering Services; CSAs; DHCD; Maryland Department of Disabilities (MDOD); Developmental Disabilities Administration (DDA); local housing authorities; housing developers

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA's priority for Administration-Sponsored Capital Program grant (Community Bond) financing is the development of affordable housing projects. Through the DHMH Community Bond a total of \$4.8 million was approved for FY 2013 to serve individuals with mental health needs, by providing new housing options. To date, more than 550 housing units have been developed through Community Bond funding in partnership with community housing development organizations, mental health provider organizations, and other entities such as: Main Street Housing, Prologue, Humanim, Housing Unlimited, Way Station, Supported Housing Developers, Community Housing Associates, Key Point, Alliance, Family Services Foundation, Mosaic, Crossroads, People Encouraging People, Project PLASE, etc. Additionally, other supported housing providers, as well as a few developers, have applied for tax credits through DHCD and are working on

blended funding projects to serve individuals coming out of the state hospitals or stepping down from residential rehabilitation programs (RRPs).

On January 24, 2013 MHA and DHMH Community Bond staff convened an annual pre proposal announcement meeting for developers, non-profit organizations, and providers of mental health services, to inform them about the benefits of community bond funding as a way to increase affordable housing options and to explain the application process. More than 20 provider/organizations were represented and encouraged to apply for the FY 2015 Community Bond. The number of applicants for FY 2015 awards totaled eight. Subsequent meetings with providers were held as needed to provide technical assistance, address changes, and to delineate the inclusion of appropriate special populations.

MHA is committed to diverting individuals from admissions and/or discharging individuals from the hospitals to assist in further reducing the hospital census and giving individuals access to the most appropriate level of care. This includes individuals transitioning from RRP to Supported Housing so that individuals in state hospitals may access the vacant RRP beds. In 2011, through a collaborative effort among Springfield Hospital Center, Housing Unlimited, Inc. (HUI), and the Montgomery County CSA, community bond funding was leveraged with the goal of transitioning 20 Springfield Hospital Center patients over two years into RRP. The residents in the RRP programs would move into supported housing provided through HUI. Funding to match the Community Bond award came from Springfield Hospital Center budget to offer rental assistance to tenants moving into the units. To date, 16 individuals have been placed in HUI supporting housing units (with a minimum of four to be placed in FY 2014).

In May 2011, an announcement was made by Governor Martin O'Malley to highlight efforts between DHCD, Weinberg Foundation, and DHMH to fund non-profit developers with capital financing to offer housing units to persons at Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) level of income. Under a Memorandum of Understanding, the Weinberg Foundation and the above mentioned state agencies will be working together to finance affordable, quality, independent, integrated housing opportunities for persons with disabilities who have very low incomes and meet certain eligibility criteria. The Weinberg units will house non-elderly, disabled households at 15-30% AMI (Area Median Income) who pay 30% of their income for rent. MHA continues partnering with DHCD and Maryland Partnership for Affordable Housing (MPAH) to determine waiting list for Weinberg Foundation units, HUD 811 initiatives, as well as use of alcohol tax revenue toward future housing initiatives.

In an effort to enhance the internal process of tracking funded units that have been completed, as well as follow the progress of recent awardees, the MHA Office of Planning and Training and the MHA Housing Coordinator will further develop the mechanism to review projects and collect data.

**Strategy Accomplishment:**

This strategy was achieved.

(5-1B)

MHA will analyze data related to entry and exit from residential rehabilitation program (RRP) placements to identify characteristics associated with successful movement from RRP to more independent settings and develop strategies to disseminate relevant findings to the provider community.

Indicators:

- Systems Evaluation Center (UMD SEC) report of admissions and discharges to and from RRP developed and reviewed
- Analysis plan developed and implemented to study information from current practices within the RRP
- Findings incorporated into future planning for RRP
- Continued updates and implementation of the RRP Survey Manual developed by hospital staff, providers, and CSAs to transition individuals to the community
- Information about movement of individuals in RRP to supported housing residents and filled vacancies with hospital individuals distributed to the CSAs, CBH, and the RRP Survey group every three months or as data is available

Involved Parties: Penny Scrivens, MHA Office of Adult Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Robin Poponne, MHA Office of Planning and Training; Marian Bland, MHA Office of Special Needs Populations; UMD SEC; DHMH Office of Capital Planning, Budgeting, and Engineering Services; CSAs; MHA facilities; CBH; RRP providers; supported housing providers

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In FY 2013, MHA conducted an ongoing group with RRP providers, CSAs, and state hospitals to reduce the number of vacancies in the RRP, identify ways to in-reach (providers coming on-site to meet and educate patients about their services) with patients in the hospital by offering access to resources such as: local and state administered funding including HOME and the HUD Community Development Block Grant (CDBG); benefit applications; delivery of Supplemental Social Security, Outreach, Access, and Recovery (SOAR) training; and conducting training for RRP providers on working with individuals with forensic needs. Case management and other agencies continue to assist individuals with disabilities to look for accessible and affordable housing. Supported Housing providers, as well as a few developers applying for tax credits through DHCD, are working on blended funding and resources already established in the community to serve individuals coming out of the state hospitals or stepping down from RRP.

The RRP statistics submitted by CSAs to MHA's Office of Adult Services is currently under review in order to evaluate data from providers, CSAs, and the ASO. MHA and the University of Maryland Systems Evaluation Center (UMD SEC) are working to link data collected from the CSAs twice a year, to an on-line format. An analysis plan is being discussed to make data available through UMD SEC reports as well as through ValueOptions@Maryland. This is scheduled for a FY 2014 implementation.

The number of consumers leaving the hospital has increased due to outreach by providers and collaboration with clinics and other community-based resources. Ongoing partnerships with local public housing authorities (PHAs) and other housing programs

have assisted with helping individuals to step down from their placement in the community to more independent housing.

The RRP Survey Manual, developed by hospital staff, providers, and CSAs to detail the process that promotes movement from RRP into Supported Housing or other independent living situations, is reviewed annually with housing information added or updated and distributed by MHA to providers, CSAs, and hospitals.

**Strategy Accomplishment:**

This strategy was partially achieved.

(5-1C)

MHA, in collaboration with CSAs, federal Department of Housing and Urban Development (HUD), local public housing authorities (PHAs), and other federal, state, and local entities, will work with housing infrastructures to improve and increase the number of housing options and funding opportunities for rental assistance for individuals with mental illnesses.

**Indicators:**

- Increased availability of vouchers through Money Follows the Person (MFP) Initiatives, the Non-Elderly Disabled HUD Notice of Funding Availability (NOFA), HUD 811-Project-based Rental Assistance (PRA), and collaboration with local public housing authorities (PHAs)
- HUD funding utilized to provide housing assistance for individuals with special needs or issues such as: TBI, co-occurring, deaf and hard of hearing, etc.
- RRP provider training continued on the needs of individuals with forensic involvement
- Collaboration with community-based entities to post available units through the Web site: [mdhousingsearch.org](http://mdhousingsearch.org)

**Involved Parties:** Penny Scrivens, MHA Office of Adult Services; Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; CSAs; DHCD; MDOD; DDA; Maryland Department of Aging (MDoA); Centers for Independent Living (CILS); local housing authorities; housing developers

**MHA Monitor:** Penny Scrivens, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA has worked toward efforts to increase availability of housing vouchers through the following processes:

- MHA participates in working with a steering committee – Maryland Partnership for Affordable Housing (MPAH) Advisory Group – chaired by MDOD and Money Follows the Person representatives, to implement the changes within the HUD 811 program in preparation for the HUD Notice of Funds Availability (NOFA), which are posted throughout the year for HUD projects.
- MHA continues to monitor [along with the Technical Assistance Collaborative (TAC) and other state and local agencies] developments in funding with HUD for special groups such as veterans, Non-Elderly Disabled (NED) vouchers, as well as the NOFA announcing new initiatives through HUD 811. As funding (including special funding that can assist with developing uniform and fair referral system) becomes available, MHA notifies agencies eligible to apply.
- Case management and other agencies assist individuals with disabilities to look for accessible and affordable housing in Carroll, Baltimore, Montgomery, and Howard counties, as well as Baltimore City, to utilize NED vouchers (Category I and II) for persons who cannot access affordable housing in senior-only buildings. In 2012, 260 NED vouchers for Category I were distributed and 112 vouchers for Category II in Maryland.

MHA participates in an ongoing interagency group meeting every other month to access vacancies and access resources and supports. MPAH will continue to monitor new grants and, along with DCHD, the further implementation of the new HUD 811 PRA program to improve affordable housing options in the state. Work with local public housing authorities (PHAs) will continue to help secure access to and stability in housing for consumers.

Under a Memorandum of Understanding, the Weinberg Foundation and state agencies are working together to finance affordable, quality, independent, integrated housing opportunities for persons with very low income who have disabilities and meet certain eligibility criteria. The Weinberg units will house non-elderly individuals with disabilities at 15-30% AMI (Area Median Income) who pay 30% of their income for rent. A referral process for Weinberg Housing units and HUD 811 (when awarded) will be coordinated through MDOD to place consumers on a waiting list for community-based supported housing is in the process of being developed. Additionally, the Weinberg Foundation announced that they will contribute another \$1,000,000 to the tax credit initiative for developers who will participate by developing affordable units within their projects bringing the total for FY 2013 to \$2,000,000.

Also, MHA works with Mental Health Association of Maryland (MHAMD) to do training, problem solving, and looking at ways to improve outcomes with individuals with mental health/substance abuse disorders leaving correctional institutions. These resources and supports include: ID process, employment, case management, housing, and ways to help improve linkages with clinics and other programs. MHA is exploring the development of training for person centered care planning as needed for providers interested in serving consumer with criminal background as well as mental health issues. MHAMD continues to be a partner in the process through participation in committees,

policy review, contracts for services, and other measures to improve efforts to serve persons with criminal involvement.

Additionally, the DHCD Web site, [mdhousing.org](http://mdhousing.org), continues to be a resource for landlords to post vacancies and for case managers and tenants to explore possible available units. MHA is working with Social Serve which monitors the [mdhousingsearch.org](http://mdhousingsearch.org) Web site to link vacancies with consumers looking for housing.

**Strategy Accomplishment:**

This strategy was achieved.

(5-1D)

Identify partners to support accessible, affordable, and inclusive housing to consumers and families across the life span - children and families, transition-aged youth, and older adults - in addition to individual adult eligibility.

**Indicators:**

- Agencies that provide housing in Maryland surveyed to look at models for providing housing across the life span
- Models identified that support person centered care planning, cultural diversity, access to services, and promote health and well-being to individuals of all ages
- Recommendations made for support of models to be integrated into current planning for future housing expansion

**Involved Parties:** Penny Scrivens, MHA Office of Adult Services; Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; MHA Office of Child and Adolescent Services, CSAs; DHCD; MDOD; DDA; MDoA; behavioral health providers, CILS; local housing authorities; housing developers

**MHA Monitors:** Penny Scrivens, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In FY 2012, agencies that provide supported housing in Maryland were surveyed to look at their models for providing housing across the life span. Housing models such as group homes, transitional housing, independent 1-2 bedroom apartments, etc. were documented. This also included housing that addresses the need for physical accommodations. The survey results are available to assist in identifying housing models that support person centered care planning, cultural diversity, access to services, and promote health and well-being to individuals of all ages.

The results will be reviewed in conjunction with criteria for Medicaid's Balancing Incentive Program (BIP). This program aims to increase shifts in state Medicaid spending towards community-based care. While recommendations are not yet developed, MHA will be looking at the results and the BIP criteria to support models that will be integrated into current planning for future housing expansion.

MHA staff is currently working with Medicaid's BIP Committee and will continue to identify recommendations for housing and community supports.

**Strategy Accomplishment:**

This strategy was partially achieved.

**Objective 5.2. Continue to work collaboratively with appropriate agencies to improve access to mental health services for individuals who are homeless.**

(5-2A)

Re-align the Projects for Assistance in Transition from Homelessness (PATH) funding to focus services on the delivery of outreach, case management, integrated services, and recovery for individuals who are homeless or at imminent risk of becoming homeless.

Indicators:

- Submission of application to Substance Abuse and Mental Health Services Administration (SAMHSA) for continued PATH funding
- Provision of technical assistance to providers and CSAs to realign services to meet funding priorities
- Utilization of a small portion of grant to provide one-time-only funds to prevent eviction
- Data gathered on number of individuals who are homeless and are assisted through PATH

Involved Parties: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; other MHA staff; CSAs; PATH service providers; housing, human services, and other homeless services providers

MHA Monitors: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The PATH program provides services to individuals who were homeless or at imminent risk of becoming homeless. In FY 2013, the PATH program continued to provide funding to all 23 counties and Baltimore City. The total federal funding was \$1,281,000 for FY 2013. There was a decrease in funding by \$3,000. Many people were reached, enrolled, received case management, linked to services in the community, and provided housing assistance. PATH met its target goal, of serving more than 4,000 individuals. This includes 6,839 people contacted and 2,296 individuals enrolled in PATH.

The Maryland PATH contact provided on-going technical assistance to providers and CSAs to ensure they met funding priorities consistent with SAMHSA Recovery model initiative. In addition, four (quarterly) meetings were convened during this reporting period and quarterly reports submitted which illustrated a snapshot of services provided during the year and the number of people who are homeless and assisted through PATH. An Annual Progress Report (APR) was submitted to MHA and SAMHSA by providers which also included statewide data on services received and individuals who are homeless and were assisted through PATH for the year. Additionally, PATH has five counties approved to provide one-time-only funds to prevent evictions. This year 34 individuals were assisted.

This program was successful because 19 out of the 25 PATH providers in the state of Maryland provide outreach services and case management which is SAMHSA's goal to link individuals to community mental health and other services as needed.

**Strategy Accomplishment:**

This strategy was achieved.

(5-2B)

Maximize use of the Shelter Plus Care Housing funding and other support systems to provide rental assistance to individuals with mental illness who are homeless, or were formerly homeless, using federal Department of Housing and Urban Development (HUD) funding.

**Indicators:**

- Partnerships developed and sources of funding researched to meet needs of women with children who are transitioning to the community
- Application for funding submitted

**Involved Parties:** Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; Penny Scrivens, MHA Office of Adult Services; ADAA; CSAs; MHA facilities; Continuum of Care Homeless Boards; local detention centers; HUD; Chrysalis House Healthy Start Program; local service providers; consumers; case management agencies; housing authorities; other nonprofit agencies

**MHA Monitors:** Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA provides federal HUD funding to CSAs to provide rental assistance to individuals who are homeless or were formerly homeless. This fiscal year (2013), HUD funded MHA's Shelter Plus Care Housing in the amount of \$4.6 million for a total of 317 units. However, MHA Shelter Plus Care program did extremely well with maximizing the budget and obtaining additional housing. The program provided rental assistance to 187 families, 191 single individuals, 342 children along with 59 other adults. In total, 779 persons were housed in 378 Shelter Plus Care units (an additional 61 units).

MHA's Office of Special Needs Populations continues to: participate in local Continuum of Care Homeless Boards; provide technical assistance to providers on a daily basis via telephone, email, or written correspondence; and assist with resolving crisis situations or handling problematic situations that may occur. In addition, MHA meets with CSAs, case managers, consumers, Shelter Plus Care monitors, and providers quarterly. Annual Performance Reports (APRs) submitted to HUD quantify the amount of individuals served as well as supportive services received during the course of the year. Also, every county that provides Shelter Plus Care Housing enters information into the Homeless Management Information System. This information includes bed and housing inventory on all individuals and families that are in the program and reports to verify the actual count of people being served in the rental assistance program.

Additionally, Shelter Plus Care is an option offered to women and children in the Chrysalis House/Healthy Start program, a statewide diagnostic and transitional program for justice system involved, pregnant women as an alternative to incarceration. It is available, as needed, for women leaving the program and re-entering the community.

In November 2012, MHA re-applied for funding of its 19 Shelter Plus renewal grants and received approval in March 2013 for \$4.8 million for FY 2014 for a total of 317 units. MHA estimates, once again, an increase in the amount of housing units provided in the coming year.

**Strategy Accomplishment:**

This strategy was achieved.



(5-2C)

Expand the SSI/SSDI Outreach, Access, and Recovery (SOAR) program statewide to further develop an integrated behavioral health model to improve access to services.

Indicators:

- Additional SOAR sites developed, new partners trained in SOAR, and workgroups formed
- SOAR certification expanded across all established SOAR sites
- State Planning workgroup expanded
- New partnerships established with the ADAA, the Veterans Administration, colleges and universities, prisons and jails, hospitals, and other state and local agencies
- Data collated and submitted to State Stat on a monthly basis
- Technical assistance provided to develop local planning groups, create local SOAR projects, and increase knowledge of the SOAR application process and data collection tool
- Social Work students assigned to field sites
- Funding sources, other than PATH, researched and obtained to support SOAR implementation and services

Involved Parties: Marian Bland, Caroline Bolas, and Keenan Jones – MHA Office of Special Needs Populations; Policy Research Associates; Social Security Administration – Disability Determination Services; colleges and universities; ADAA; DPSCS; DHR; Veterans Administration; PATH-funded providers; other community and facility-based providers

MHA Monitors: Marian Bland and Caroline Bolas, MHA Office of Special Needs Populations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Due, in part, to the many effective partnerships that have been developed since MHA took over the project in 2008; the SOAR Initiative within Maryland continued to expand. A number of new sites, increased community providers, and increased eligible applicants were evidenced in FY 2013. In turn, this program has brought a significant amount of federal dollars into the state.

MHA's Office of Special Needs Populations continued to provide on-going technical support to those counties that have previously implemented SOAR; namely, Anne Arundel, Baltimore, Carroll, Frederick, Harford, Howard, Montgomery, Prince George's, St. Mary's, Somerset, Washington, Worcester, and Wicomico counties and Baltimore City. Additionally, in FY 2013 MHA worked with Cecil and Garrett Counties to develop their work plans and undertake SOAR training. Both counties are now working on SOAR claims. MHA also held start-up meetings and provided on-going support to a workgroup in Allegany County which is currently developing its plan.

During the reporting period, 110 people completed four two-day Stepping Stones to Recovery trainings which provided an in-depth, step by step explanation of the SSI/SSDI application and disability determination process. Participants consisted of case managers, PATH providers, human service providers and social workers. Additionally MHA, in conjunction with representatives from community providers and Disability Determination Services, gave presentations about SOAR at six conferences in FY 2013.

At the end of FY 2012, MHA started a pilot SOAR Certification Program in Baltimore City and Montgomery County. The purpose of the program is to ensure high quality applications and provide recognition for all the hard work that goes into completing SOAR applications. As of the end of June 2013, nine providers held provisional status and eight people held full certification status. It was agreed before expanding the program further that an evaluation would be carried out at the end of FY 2013. This has been completed and its findings will be reviewed by the State Planning Workgroup early in FY 2014.

Approved SOAR applications numbered 165 (81% approved) with the average processing time of 71 days (2 ½ months) for initial cases. Approval rates have remained very high. This program has assisted a large number of people who have previously been denied benefits on numerous occasions, through the implementation of the key components of SOAR, to apply and be approved. This has led to better health care, housing and in some cases a return to employment. During FY 2013, Maryland was named a SOAR Superstar state by the SOAR National Technical Assistance (TA) Center as it has the joint 4<sup>th</sup> highest approval rate for initial claims within the country. Data has been submitted every month on time. Additionally, comprehensive annual data was submitted to PRA.

A number of new representatives joined the State Planning Work Group, including representatives from SSA, DHR and PRA. One of the new dedicated SOAR case managers is focused on working with veterans and is establishing partnerships with the VA in Baltimore. Three people from the Maryland Brain Injury Association were recently SOAR-trained. A number of individuals involved in jail re-entry have also been trained during the year, including workers involved in the new Second Chance grant to serve approximately 75 offenders with moderate to high risk histories of chronic mental illness and substance use and/or dependence issues to establish or re-establish community linkages.

MHA is currently working with the State Hospitals and SSA to agree on a process to help expedite the reinstatements of benefits for eligible individuals leaving the hospital. A social work student at Health Care for the Homeless worked on SOAR cases during FY 2013. Additionally, a number of undergraduate interns (representing the disciplines of social work, public health, and others) worked with the SOAR project in Montgomery County.

The SOAR TA team has provided trainings and on-going support to the local SOAR Leads, Workgroups, and dedicated SOAR case managers. A review of the 2012 State Work Plan demonstrated the significant progress had been made toward all of the agreed goals and a new plan was developed for calendar year 2013. This will continue to ensure that appropriate TA is provided to continue the successful growth of SOAR.

The SOAR Leads who coordinate the SOAR process in their jurisdictions have played an important role in ensuring the continuing success of SOAR within the state. At the local level, jurisdictions continued to partner with substance use agencies. The National TA center hosted a Webinar on SSA's policies on drug and alcohol and how SOAR can be used to ensure those with co-occurring disorders who are eligible actually get approved. This was promoted to all SOAR trained staff.

In FY 2013, funding from Maryland's Alcohol Tax Appropriation enabled the funding of five dedicated SOAR case managers as part of the Homeless ID Project. These positions are based in Baltimore City (focusing on the Veteran population), and Baltimore County, Frederick County, Montgomery County and the Lower Eastern Shore. A two-day specialized training for the five dedicated ID Fund SOAR case managers was provided.

**Strategy Accomplishment:**

This strategy was achieved.

## **GOAL VI. UTILIZE DATA AND HEALTH INFORMATION TECHNOLOGY TO EVALUATE, MONITOR, AND IMPROVE THE QUALITY OF BEHAVIORAL HEALTH SYSTEM OF CARE SERVICES AND OUTCOMES**

**Objective 6.1. MHA, in collaboration with Core Service Agencies (CSAs); consumer, family, and provider organizations; and state facilities will identify and promote the implementation of models of evidence-based, effective, promising, and best practices for mental health services in community programs and facilities.**

(6-1A)

*\*Federal Mental Health Block Grant*

Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education; also explore pilot implementation of Integrated Illness Management and Recovery (IIMR) program.

Indicators:

- Programs evaluated annually to determine eligibility for EBP rates
- Increased number of programs meeting fidelity standards for EBP programs
- Number of new programs established
- Ongoing data collection on EBPs receiving training, meeting fidelity, and providing consumer services
- Pilot implementation of IIMR at selected sites

Involved Parties: Steve Reeder - MHA Office of Adult Services; Brian Hepburn, MHA Office of the Executive Director; Gayle Jordan-Randolph, MHA Office of the Clinical Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Carole Frank, MHA Office of Planning and Training; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; ValueOptions@Maryland; Dartmouth Psychiatric Research Center; the University of Maryland Evidence-Based Practice (UMD EBPC) and Systems Evaluation (UMD SEC) Centers; CSAs; community mental health providers

MHA Monitors: Steve Reeder, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA provides fidelity monitoring and has contracted with UMD EBPC to provide technical assistance and consultation to new and existing evidence-based practice (EBP) programs. Way Station, Inc. through funding from the Weinberg Foundation, is furnishing additional technical assistance and consultation to all Sheppard Pratt affiliated agencies that provide supported employment (SE) services. The number of consumers received EBP SE services in FY 2013 was 2,287. Consumers who received EBP assertive community treatment (ACT) services in FY 2013 numbered 1,793. Nineteen (19) different providers are offering forty six (46) Evidence Based Practices at selected sites throughout Maryland. There were no new Family Psycho-education (FPE) providers in FY 2013, but the existing providers continued the practice by starting new FPE groups. A total of 19 individuals attended FPE groups in FY 2013.

Fidelity assessments, for programs offering the EBPs of assertive community treatment (ACT), family psycho-education (FPE), and (SE), are conducted annually by MHA Fidelity Monitors to determine each program's eligibility to receive the enhanced EBP reimbursement rate. Sites must score a minimum of 4.0 on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at the enhanced rate. One FPE program, 16 SE, and nine ACT (for a total of 26) EBP programs were monitored for adherence to fidelity in FY 2013. Three of the nine ACT teams, that were assessed for and met fidelity, were new providers. They are serving consumers in Carroll, Howard, and Eastern Baltimore counties. ACT fidelity assessments were conducted with a new instrument, the *Tool for Measurement of Assertive Community Treatment* (TMACT). This tool improves the evaluation of the quality of services. A co-developer of the TMACT continued to provide training to fidelity monitors and participated in evaluating three ACT teams in FY 2013. Some ACT teams are receiving training in providing evidence-based FPE and SE from University of Maryland consultants. Linking DORS counselors to ACT teams continues to be implemented as an important part of the monitoring process.

Two SE providers in Southern Maryland expanded services to adjacent counties. Southern Maryland Community Network, a provider in Calvert County, is now serving consumers in St. Mary's County. Pathways, a provider in St. Mary's County, is serving consumers in Charles County. Additionally a provider in Anne Arundel county expanded services to Baltimore City as two new providers in Baltimore City had their initial fidelity assessment. These providers were not yet deemed as an EBP but are receiving technical assistance and fully expect to reach fidelity when the monitors return in FY 2014. As of July 1, 2012 ACT teams have been submitting monthly outcomes data to MHA and the Baltimore City CSA. Also, monthly outcome data are collected from all SE providers and SE providers-in-training by the University of Maryland.

Integrated Illness Management and Recovery (IIMR), an EBP that provides information, support, and skills to help consumers manage their mental illnesses and somatic features as they move forward in their own recovery process, is being implemented by one provider at three sites - Howard, Washington, and Frederick counties. The IIMR provider is receiving training from the Dartmouth Psychiatric Research Center and is including MHA and the University of Maryland as it progresses. Beginning in February of 2013, MHA fidelity monitors have participated in monthly technical assistance calls between Dartmouth and the IIMR provider.

**Strategy Accomplishment:**

This strategy was achieved.

(6-1B)

*\*Federal Mental Health Block Grant*

MHA, in conjunction with the University of Maryland Systems Evaluation Center (UMD SEC), will aggregate, cross-match, and triangulate data from multiple data sources related to the implementation of supported employment (SE) to ensure the integrity and accuracy of data as a means to promote systems integration and to further inform data-driven, interagency policy development and program planning.

Indicators:

- SE claims and Division of Rehabilitation Services (DORS) data analyzed; EBP provider reports completed
- Report submitted by UMD SEC
- Information disseminated to provider community
- Strategies developed, findings incorporated into future planning

Involved Parties: MHA Office of Adult Services; UMD EBPC and UMD SEC; DORS

MHA Monitors: Steve Reeder, MHA Office of Adult Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In collaboration with MHA, DORS, and the Evidence-Based Practice Center (UMD EBPC), staff of the UMD SEC performed comparisons of the reports of consumer employment as recorded in DORS data system and reported to the UMD EBPC. Most individuals who were reported in the DORS management information system also had a Public Mental Health System (PMHS) SE claim on file. PMHS claims data have been compared with EBP data and a brief analysis has been generated. PMHS claims have also been matched with DORS data in individuals who appear in one data set but not the other. These data have been forwarded to DORS and MHA program staff for a review of the cases to determine the reasons for missing DORS cases or PMHS claims identified in comparing the files. UMD SEC and DORS staff have jointly completed the identification of cases and information will be shared with providers on a case by case basis.

Discrepancies seemed to be provider specific rather than system error. Where anomalies are found, MHA and DORS will follow-up with these individual providers and make recommendations where appropriate. Perhaps programmatic review will be required.

The proposed data analysis has been completed. MHA will continue to meet with UMD SEC to review and discuss the data, to determine follow-up strategies, and to incorporate such strategies into future interagency policy development and program planning efforts.

Additionally, MHA receives quarterly reports on outcome measures collected from supported employment EBP providers.

**Strategy Accomplishment:**

This strategy was achieved.

(6-1C)

MHA's Office of Special Needs Populations, in collaboration with the Core Service Agencies, local detention centers, DHMH, DPSCS's criminal justice team, and other key stakeholders, will develop and implement new practices to provide cost effective, coordinated, recovery-oriented services to individuals who have mental illnesses or co-occurring substance abuse disorders who are incarcerated in local detention centers or prisons.

Indicators:

- Identification of pre-trial/post-trial assessment best practices
- Engagement in partnerships to promote data sharing to assist with community re-entry
- Engagement of Wellness and Recovery Centers (WRC) in aftercare planning
- The feasibility assessed of the Maryland Community Criminal Justice Treatment Program (MCCJTP) to meet the aftercare needs of its participants

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; Debra Hammen, MHA Office of Forensic Services; Core Services Agencies; local detention centers; MHAMD; WRCs; ADAA; DDA; community behavioral health providers; DHMH, DPSCS, the Baltimore City Core Service Agency; CSAs, the Maryland Correctional Administrators Association (MCAA); Prisons, Detention Centers, Advocacy groups

MHA Monitors: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA, through the Maryland Community Criminal Justice Treatment Program (MCCJTP), continues to collaborate with the CSAs to assist local leaders of mental health correction services in the identification of inmates with mental health concerns, completion of assessments, and (as appropriate) provision of interventions to this population. Quarterly reports for MCCJTP reflect: the number of individuals referred to the program; number who entered the program; and the aggregate number of hours utilized to provide psychiatry, counseling, and aftercare planning. At this time, the Mid-Shore region and Frederick, Howard, Baltimore, Calvert, Garrett, Charles, and Carroll counties are actively seeking to modify MCCJTP to include a diversion program through mental health courts or re-entry services. The feasibility of re-aligning the program to focus on aftercare is being evaluated and in FY 2014 MHA will put into place additional enhancements for aftercare service monitoring for MCCJTP.

MHA continues its collaboration with DPSCS, the Maryland Correctional Administrators Association, CSAs, and other partners to identify best practices, such as specified tools for pre-trial mental health assessments. All detention centers screen for mental health issues through their medical unit. Assessment tools, such as the Brief Jail Mental Health Survey, the Cage Assessment Tool, and Adverse Childhood Experiences (ACE) survey currently in place in local detention center focusing on trauma services. The Brief Jail Mental Health Screen is most recommended in the jail funded programs to identify mental health issues, although third party vendors in contract with the CSAs may utilize different screening and assessment tools.

Also, a special criminal justice team, comprised of MHA's Office of Special Needs Populations, CSAs, and representatives from ADAA and Maryland Department of Public Safety and Correctional Services (DPSCS), worked collaboratively to re-initiate an initiative called DataLink, which enables the sharing of public mental health system treatment information with detention centers. DataLink, is established in Baltimore City and Howard and Anne Arundel counties and a DataLink subcommittee has been established to determine new sites for expansion, develop public health outcomes, troubleshoot, and provide technical assistance to new and existing sites. Booking data is sent by the DPSCS to the administrative service organization for MHA, ValueOptions®Maryland (VO), and cross-referenced against information in the PMHS. Simultaneously, the data is also shared with the local CSA who may assist in providing coordinated care for the individual while detained and upon release. Based on FY 2013 data shared by DPSCS, 91,847 individuals were identified who had an interaction with law enforcement. Of the 91,847 individuals, VO identified 21,491 as Medicaid consumers. Additionally, DHMH has provided more than 40 DPSCS staff online access to Medicaid Management Information System (MMIS) eligibility screens and the agencies are collaborating in a daily exchange of inmate data so that DHMH can more readily identify those clients that have been incarcerated.

**Strategy Accomplishment:**

This strategy was partially achieved.



**Objective 6.2. MHA will monitor and evaluate the performance of its key contractors the administrative service organization (ASO) and the Core Service Agencies (CSAs), requiring improvement as needed.**

(6-2A)

*\*Federal Mental Health Block Grant*

In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care for at least the same number of individuals.

Indicators:

- Contract requirements monitored
- Information shared with key stakeholders
- Monthly and quarterly reports generated by ASO; analysis of reports by involved parties
- Analysis of utilization management practices

Involved Parties: Daryl Plevy, MHA Office of the Deputy Director for Community Services and Managed Care; Audrey B. Chase, MHA Office of Compliance; MHA Office of CSA Liaison; Fiona Ewan, MHA Office of Fiscal Services; MHA Management Committee; ValueOptions@Maryland; CSAs; representatives of key stakeholder groups

MHA Monitor: Daryl Plevy, MHA Office Deputy Director for Community Services and Managed Care

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The contract requirements of the administrative services organization (ASO) are monitored for compliance with corrective actions taken as necessary. Monthly and quarterly reports are: generated by the ASO; analyzed by involved parties; and shared (information related to PMHS services including cost, number served, services provided, and types of diagnoses) with key stakeholders. Reports are used to inform decisions related to PMHS planning and operation. Analysis of utilization management practices is conducted to ensure that consumers are receiving timely access to the appropriate level of care.

MHA is continuing to serve individuals of all ages with mental illnesses, through its fiscal and administrative responsibility for mental health care for the total Medicaid population under the MA 1115 waiver. In FY 1999 (first year of available data), over 68,000 individuals were served. Sixty-three percent were adults and 37 percent were children and adolescents. Fifty-two percent met the diagnostic criteria for individuals with serious mental illness (SMI) and 72 percent met the criteria for individuals with serious emotional disorders (SED). Since then, the number of individuals served has grown by more than 80,000 people.

In FY 2013, MHA served 148,475 individuals who had claims paid for mental health services received through the fee-for-service system. Of the total, 91,478 were adults age 18+, (61.6%); and 56,997 (38.4%) were children and adolescents. Of the adults served, 62.8 met the diagnostic criteria for SMI and 74.39% of the children and adolescents served met the diagnostic criteria for SED. (Data collected by claims paid through June 30, 2013 and therefore is approximate due to the allowed twelve month lag in PMHS claims submission.)

**Strategy Accomplishment:**

This strategy was achieved.

(6-2B)

In collaboration with the ASO, DHMH's Office of Health Care Quality (OHCQ), DHMH's Office of the Inspector General, and CSAs, review providers' clinical utilization, billing practices, and compliance with regulations.

**Indicators:**

- Number of audits conducted
- Audit reports and compliance activities reviewed
- Corrective actions identified/implemented as needed

**Involved Parties:** Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Audrey B. Chase, MHA Office of Compliance; MHA Office of Adult Services; Al Zachik, MHA Office of Child and Adolescent Services; OHCQ; ValueOptions®Maryland; CSAs

**MHA Monitor:** Audrey B. Chase, MHA Office of Compliance

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In FY 2013, MHA's Office of Compliance worked with the ASO to ensure the completion of 72 program audits. Many were scheduled as a result of data mining activities identifying high volume or high paid billers. Others were scheduled as a result of follow-up on fraud/abuse tips and complaint investigation findings. The outcome of MHA's review of provider utilization, billing practices, and regulatory compliance was program accountability. All audits were conducted as retrospective reviews of services provided. Provider entities included psychiatric rehabilitation programs (PRPs), outpatient mental health clinics, residential treatment centers, and hospitals.

MHA initiated appropriate sanctions against providers who failed to achieve regulatory compliance within their service delivery and billing practices. Such sanctions ranged from the implementation of a program improvement plan, to monetary retraction, to program revocation. In all instances audit findings were presented in a formal audit report. MHA's Office of Compliance continues to work with the Office of the Inspector General to prevent fraud and abuse as well as identify opportunities for further investigation and recovery.

**Strategy Accomplishment:**

This strategy was achieved.

(6-2C)

Review and approve CSA mental health plans, budget documents, annual reports, and letters of review from local mental health advisory committees (LMHACs) and CSA advisory boards.

Indicators:

- Plans submitted from each CSA
- Compliance with MHA planning guidelines for CSA Plans evaluated
- Letters of review and recommendation received from each LMHAC and/or CSA board
- Previous fiscal year annual reports received
- MHA letter of review sent to the CSAs

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Cynthia Petion and Robin Poponne, MHA Office of Planning and Training; MHA Office of CSA Liaison; MHA Office of Administration and Finance; MHA Review Committee (includes representatives of all major MHA offices); CSAs; LMHACs; CSA advisory boards

MHA Monitor: Cynthia Petion, MHA Office of Planning and Training

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Each year an extensive plan development process is implemented, beginning in January, with the submission to MHA of local mental health plans and budgets from the Core Service Agencies (CSAs). The CSA Plan and Budget guidelines are developed through MHA's Office of Planning and Training to guide the development of local plans that identify priorities, strengths, needs and service gaps of the local public mental health system as well as a description of stakeholder input. An official comprehensive Plan is usually submitted by each CSA every three years with updated documents developed and submitted during the two years in between. However, due to the DHMH Behavioral Health Integration Process, CSAs were required, in FY 2013, to submit only a one-year plan for FY 2014.

The CSAs' FY 2014 Mental Health Plan and Budget documents were reviewed by a committee consisting of MHA budget, planning, special needs populations, and behavioral health services staff, as well as the MIS and OCA staff. Budget documents were submitted and reviewed first in January and February, followed by the submission of the CSA Annual Reports and Program Plans in March and April. To simplify data submissions, each CSA continued to include standardized data templates in its submission. This year, CSAs were requested to identify eight of the following eleven state priority areas (based on MHA and federal Mental Health Block Grant requirements) to discuss in-depth and to include in the goal/strategy area of the plan:

- Recovery Supports
- Public Awareness and Education
- Tobacco/Smoking Cessation
- Behavioral health workforce development efforts
- Suicide prevention
- Efforts to address co-occurring disorders/dual diagnosis capability training
- Access to services across the lifespan
- Evidence-based practices

- Health disparities/cultural competency
- Diversion efforts
- Outcomes/quality

Additionally, each plan included, as required, a letter of review with recommendations from the local mental health advisory committee of that jurisdiction or documentation of review from the CSA Board of Directors.

CSAs were also required to electronically submit their fiscal year 2012 Annual Reports. The plans and annual reports included discussions of: the CSAs' achievements; interagency collaborations and partnerships; local and statewide initiatives; and financial plans linked to mental health services. All plans were found to be in compliance with MHA's Guidelines Regarding Fiscal Year 2014 Plans/Budgets. Letters of review/approval were sent at the end of 2013.

**Strategy Accomplishment:**

This strategy was achieved.

(6-2D)

Monitor and collect documentation on each CSA's performance of its duties, as required in the annual Memorandum of Understanding (MOU), on risk-based assessment of each CSA through a sample of specific MOU elements; and notify the appropriate MHA program director of issues that may require corrective action or additional technical assistance.

**Indicators:**

- Development and update of monitoring tools and instructions for reports from each CSA, emphasizing electronic transmission
- Reports from each CSA reviewed, in response to periodic instructions issued, regarding its administrative duties and expenditures, the execution of its subvendors' contracts, year-to-date expenditures/performance measures, and any required audits
- Evaluation of compliance with the Conditions of Award for State General Funds and Federal Mental Health Block Grant funds
- Three reviews scheduled for the first, second and fourth quarters of the fiscal year
- Written letter issued to each CSA regarding each periodic report, appropriate follow-up conducted as needed

**Involved Parties:** Karen Ancarrow-Rice, Sandy Arndts and Richard Blackwell, MHA Office of CSA Liaison; appropriate MHA Office Directors; MHA staff

**MHA Monitor:** Karen Ancarrow-Rice, MHA Office of CSA Liaison

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The MHA Office of CSA Liaison conducted three quarterly monitorings by conference calls for all 19 CSAs for compliance with the MOU for FY 2013. (The fourth quarterly monitoring process [third quarter] consists of the MHA review of CSA Program Plans, Annual Reports, and Budgets.) Quarterly monitorings for each CSA's administration and for its subvendors, included:

- Review of the use of both state general funds and federal block grant dollars
- Report from each of the 19 CSAs submitted regarding the timely execution of their subvendors' contracts
- Type of contract used
- Requirement for an audit, its due date, copy of audit review
- Administrative reports on selected elements of the MOU, and a fiscal update for year-to-date expenditures
- Performance measures with projections for the fiscal year for the CSAs' administration and subvendors
- Review of the use of Consumer Support funds
- Assessment of CSA involvement in client movement within the RRP levels of service
- Assessment of CSAs' efforts toward identifying and linking military veterans to needed mental health services
- Assessment of CSAs' Mental Health Advisory Committees racial and ethnic diversity of membership
- Assessment of CSAs' Behavioral Health transition activity
- Assessment of CSAs' readiness to identify behavioral outcome measures for their contract services

The FY 2013 monitoring process emphasized timely execution of deliverables and congruency between each subvendor's operational conditions of award (COA) and the COA in the CSA contract. Selected samples of subvendors' contracts at each CSA were reviewed, including the contract, budget for cost reimbursement, programmatic report from the subvendor, invoice, payment, audit (if required), documentation of the CSA's review of the audit, site visit by the CSA, and internal controls by the CSA.

The Office of CSA Liaison prepares three quarterly reports for MHA's Deputy Director for Community Programs and Managed Care, noting particular issues such as specific information and data aggregated from MHA monitoring. MHA retains the documentation provided by the CSAs on file, providing both verbal feedback through scheduled conference calls and documentation of its findings for each CSA, copied to the MHA Management Committee and available for review in the MHA Office of CSA Liaison.

**Strategy Accomplishment:**

This strategy was achieved.

(6-2E)

Review MHA's budget and behavioral health system of care expenditures and services; implement corrective actions, as needed, to maintain operations within allocation.

Indicators:

- Quarterly expenditure management plans developed and reviewed
- Regular meetings held with MHA facility chief executive officers (CEOs)
- Expenditures and needs reviewed by clinical directors and financial officers

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Marion Kasteles, MHA Office of Administration and Finance; Gayle Jordan-Randolph, MHA Office of the Clinical Director; MHA Facility CEOs; DHMH; Legislative Analysts; clinical directors; financial officers; ValueOptions@Maryland; CSAs; providers

MHA Monitors: Brian Hepburn, MHA Office of the Executive Director and MHA Office of Administration and Finance

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

MHA monitors facility budgets regularly and reviews developed expenditure plans and reports. Quarterly reviews are held regularly, plus additional meetings and reviews are held on an ad hoc basis. Corrective actions are developed and implemented consistent with applicable regulations, policies and procedures. Also, MHA and the ASO have reviewed weekly and quarterly expenditure and utilization reports to ascertain trends in service delivery and/or spending. This information is used to develop strategies for managing the budget, amending current MHA policies as needed, and correcting any problems that may be identified. Additionally, the CSAs routinely review various Crystal Reports detailing claims and utilization for consumers and providers within their respective counties.

Efforts continue to be monitored in the PMHS including the review of individuals who are uninsured to determine if applicable entitlement benefits have been received. This includes the Primary Adult Care (PAC) program. Uninsured individuals enrolled in the PAC now have MA coverage for most mental health care (excluding hospital emergency room service, inpatient, and outpatient hospital-based services).

Another significant result of the current budget processes is a long-term, ongoing trend to promote less costly community-based services while continuing to meet the expanding demand for PMHS services. These efforts result in a lower average cost per individual consumer served and is reflected in the various utilization data reports monitored by MHA and the CSAs. MHA management meets with other PMHS partners as required to seek solutions to budgetary matters while continuing to provide authorized services.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 6.3. MHA, in collaboration with CSAs, state facilities, the administrative services organization (ASO), other state agencies, and key stakeholders, will utilize data and health information technology, through a variety of approaches, to evaluate and improve the appropriateness, quality efficiency, cost effectiveness, and outcomes of mental health services within the behavioral health system of care.**

(6-3A)

Continue to monitor the implementation of the Outcomes Measurement System (OMS).

Indicators:

- Reestablishment of implementation of OMS monitoring, reporting, and feedback mechanisms including OMS expenditure analysis
- Review of provider utilization rates; resolution of identified problems
- Continued provision of technical assistance to providers and CSAs regarding use of the OMS Datamart, once it is fully operational

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Sharon Ohlhaver, MHA Office of Quality Management and Community Programs; Sheba Jeyachandran, MHA consultant; MHA Management Committee; ValueOptions@Maryland; CSAs; UMD SEC; CBH; providers; consumer, family, and advocacy groups

MHA Monitor: Sharon Ohlhaver, MHA Office of Quality Management and Community Programs

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In FY 2012, ValueOptions@Maryland (VO), the UMD SEC, and MHA collaborated to complete the complex tasks necessary to reestablish the interactive Web-based OMS Datamart. Following a data validation process in FY 2013, the OMS Datamart has been refreshed quarterly. Regular monthly meetings with VO are used to discuss and resolve any OMS issues that arise. VO has implemented a more comprehensive plan for monitoring provider utilization and expenditures through its Quality Incentive program (QuIP) and the assessment of OMS completion rates is a part of that effort. Through VO's Provider Alerts, MHA has continued to encourage providers to access provider level data.

OMS templates for CSAs to use in their annual planning process have been developed by the UMD SEC. MHA and UMD SEC held two meetings with CBH providers to discuss tools and technical assistance that are needed to assist in OMS data interpretation. As a result of those discussions UMD SEC, in collaboration with MHA, is developing a workbook and other training materials.

**Strategy Accomplishment:**

This strategy was achieved.

(6-3B)

MHA will continue to monitor the utilization of telemental health services to the underserved populations in the rural Western and Eastern Shore counties.

Indicators:

- Number of telemental health encounters through behavioral health system of care claims data
- Utilization of telemental health services monitored
- Data reviewed with designated area CSAs to inform planning

Involved Parties: Daryl Plevy, MHA office of the Deputy Director for Community Services and Managed Care; Melissa Schober, MHA Medicaid Policy Analyst; CSAs; ValueOptions®Maryland

MHA Monitor: Melissa Schober, MHA Medicaid Policy Analyst

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

As of FY 2013, fourteen providers and local health departments across the state, mostly from the Lower and Eastern Shore, became telemental health providers and participated in telemental health service encounters:

- QCI Behavioral Health
- Pressley Ridge
- Delmarva Family Resources (Community Behavioral Health)
- Eastern Shore Psychological Services
- Cecil County Local Health Department (LHD)
- Wicomico LHD
- Worcester LHD
- Caroline LHD
- Pathways, Inc.
- Maple Shade Youth and Family Services
- Three Lower Counties Community Services federally Qualified Health Center (FQHC)
- Lower Shore Clinic in Salisbury
- Garrett County Outpatient Mental Health Clinic (OMHC)
- Walden Sierra

Garrett County Lighthouse, Upper Bay, and Vesta are scheduled to begin telemental health services in FY 2014.

The CSAs continue to promote the development of a provider network in their jurisdictions. MHA monitors utilization through the number of unique individuals using telemental health services and has found that the average monthly amount of individuals receiving telemental health services is 254. The results have shown improved access and reduced barriers for a number of services. For example, a variance for Garrett Lighthouse was approved so individuals receiving psychiatric rehabilitation services could see a remote psychiatrist in order to access crisis beds when needed.

**Strategy Accomplishment:**

This strategy was achieved.



(6-3C)

Enhance capacity for stakeholders to utilize behavioral health system of care data to measure service effectiveness and outcomes.

Indicators:

- Combined data efforts between MHA and CSAs maintained to evaluate current data system and data reports used for the purpose of policy and planning by CSAs and other stakeholders
- Input gathered from stakeholders on the practicality and efficacy of reports; technical assistance and regional trainings held as necessary
- Access to data increased to develop standard and ad hoc reports
- Expanded data usage opportunities to the public and stakeholders outside of MHA through the UMD SEC
- Reports generated and posted to designated data reporting section on administrative Web site, making behavioral health system of care demographic data available to users outside of state agencies
- Promotion of managerial and county-wide access to dashboard reports and Public Mental Health System (PMHS) data through ASO reporting system

Involved Parties: Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Cynthia Petion, MHA Office of Planning and Training; Sharon Ohlhaber; MHA Office of Quality Management and Community Programs; MHA consultant; MHA Management Committee; ValueOptions@Maryland; UMD SEC; CSAs; the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council; provider, consumer, family, and advocacy groups

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Monthly data and information technology (IT) conference calls are conducted with ValueOptions@Maryland, the existing ASO, to ensure proper execution of logic behind data reports and that all business rules are predefined. Reporting systems were fine tuned to promote ease of use. Bi-monthly meetings are held to discuss: data reports; trainings to help with accessing data system; utilization of the data for trending and analysis; and trouble-shooting of existing reports. MHA's Office of Management Information System (MIS) and the Office of Planning and Training are represented, as well as ASO, UMD SEC and CSA members. The meetings are also used as a vehicle to filter data-specific information to all interested stakeholders and allow committee members the opportunity to make suggestions for the overall enhancement of the PMHS data system.

In collaboration with the ASO, MHA created standardized policy to provide ad hoc reports requested by CSAs in response to suggested budget cuts and methods of combating projected budget strategies. Email alerts, reporting at Executive Level meetings, and dissemination of reports and step-by-step instructions to access dashboard reports occurred as a part of this process. Dashboard reports remain on-site for Executive Level staff usage. CSAs and providers were given access to county-specific and client-level OMS data. Additionally, technical assistance in data usage opportunities was expanded to the public and stakeholders outside of MHA through the UMD SEC.

Quarterly reports and specialized data reports, as well as monthly Statestat reports, are posted regularly for public consumption on the Administration's Web site

<http://dhmh.maryland.gov/mha>.

OMS public Web-based datamart is functional and provides outcomes data at the county specific level. Implementation for provider level data is forthcoming.

Brief introductions to the Outcomes Measurement System (OMS) public Web-based datamart site and suggestions on how to use the data towards planning and policy were shared through alerts, Web site notices, trainings, and a break out session at the 2013 MHA Conference. Also, in the spring of 2013, the UMD SEC convened a Behavioral Research Conference attended by approximately 120 behavioral health professionals. MHA and others shared brief reports of data research/accomplishments in the area of behavioral health.

**Strategy Accomplishment:**

This strategy was achieved.

(6-3D)

Monitor the delivery of forensic services and generate statistical information to inform policy and promote public awareness.

**Indicators:**

- Number and results of court-ordered evaluations, the number and percentage of individuals in DHMH facilities on court order, and the number and success of consumers on court-ordered conditional release in the community
- Reports submitted to MHA Management Committee, the CSAs, and the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

**Involved Parties:** Larry Fitch, Debra Hammen, and staff - MHA Office of Forensic Services; Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Gayle Jordan-Randolph, MHA Office of the Clinical Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis

**MHA Monitor:** MHA Office of Forensic Services

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

Ongoing monitoring of approximately 1,000 consumers on pre-trial and conditional release continued in FY 2013, including reports to the State's Attorney as appropriate. The number of court ordered evaluations were tallied by MHA's Office of Forensic Services staff, in collaboration with the CSAs, and from monthly reports of completed evaluations. Data outcomes were collected for approximately 1,455 adult community-based court ordered pre-trial evaluations, 140 pre-sentence psychiatric evaluations, 63 presentence sex offender evaluations, and 110 juvenile court competencies-to-proceed evaluations. This data was reported in FY 2013 to assist the CSAs and other PMHS leadership in planning efforts.

Committee reports and proceedings continue to be submitted regularly to MHA and the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-31 Planning council.

**Strategy Accomplishment:**

This strategy was achieved.

(6-3E)

Implement an integrated approach for the collection, analysis, and use of data in a behavioral health system.

Indicators:

- Recommendations identified from the DHMH Data and Evaluation Workgroup on behavioral health integration

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; UMD SEC; ValueOptions@Maryland; CSAs

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis;

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

The DHMH Data and Evaluation Workgroup on behavioral health integration met in FY 2012 to begin to examine similarities in MHA and ADAA data systems and data collection methodology and also explore best methods to integrate behavioral health and somatic data. The group also explored, through the SAMHSA Data Infrastructure Grant (DIG), the feasibility of reporting PMHS client level statistics with ADAA's Treatment Episode Data Set (TEDS) data. The group did not meet in FY 2013 due to personnel changes. However, it was decided that data from each administration could be shared without actually combining the data systems. Enhancement of the DIG is supporting further investigation into these areas. In FY 2014 a recently awarded grant, funded through SAMHSA's Center for Behavioral Statistics and Quality (CBHSQ), will allow continued work toward integrated data reports.

Additionally, the Outcomes Measurement System (OMS), an interactive Web-based system, will continue to be promoted and refined as it focuses on comparing and contrasting the OMS change-over-time data results for those consumers who have a co-occurring substance abuse disorder with results for those consumers who do not have a co-occurring substance abuse diagnosis.

**Strategy Accomplishment:**

This strategy was achieved.

**Objective 6.4. MHA, in collaboration with CSAs, the ASO, and key stakeholders, will promote the use of technology as a tool to improve information sharing, data collection, training, evaluation and performance, and outcomes.**

(6-4A)

Enhance behavioral health system of care data collection and monitoring through continued activities to develop and/or refine management information systems.

Indicators:

- Continue to refine technical aspects of management information systems; logic of reports enhanced to reflect recovery orientation and efficient use of service data; accuracy and usefulness of current reports identified
- Continued practices to promote data integrity for all behavioral health system of care data
- Continued data system integration efforts among behavioral health administrations (Mental Hygiene, Alcohol and Drug Abuse, and Developmental Disabilities)
- Continued maintenance and improvement efforts of Behavioral Health server with ADAA
- Strategies developed to identify and track users of services across administrations
- Continued participation and leadership in Behavioral Health Data Workgroup and Virtual Data Unit to promote relationships with other state agencies and data sharing

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Sharon Ohlhaver, MHA Office of Quality Management and Community Programs; Cynthia Petion, MHA Office of Planning and Training; ADAA; DDA; UMD SEC; DHMH's Information Resource Management Administration (IRMA); MA; CSAs; ValueOptions®Maryland; providers

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

In FY 2012, the Information Technology (IT) Merge/Behavioral Health Data Workgroup began the process of linking all administration computers to the Active Directory domain of ADAA in order to create a single network directory among the two administrations. In winter FY 2013, MHA completed the process.

In collaboration with Medicaid (MA), ADAA continued research and discussion regarding the further integration of data systems that would allow the identification and tracking of users of services across administrations. The process will be monitored and directed by DHMH Chief of staff. Monthly data and information technology conference calls with the ASO are conducted to ensure proper execution of logic behind data reports and reporting systems continue to be fine tuned to promote ease of use.

All technical aspects of the OMS have been resolved. Change over Time and Point in Time data are available via datamart for CSA and providers. Monthly IT calls with the ASO center around the refinement and release of relevant PMHS data reports.

MHA participates in data system integration efforts among behavioral health administrations (Mental Hygiene, Alcohol and Drug Abuse, and Developmental

Disabilities). In FY 2013, MHA attended the Autism Commission Data Workgroup and was also represented as member of the Maryland Statewide Epidemiological Outcomes Workgroup (SEOW) which monitors the use of alcohol, tobacco, and other drugs to identify and prioritize prevention and treatment needs statewide.

**Strategy Accomplishment:**

This strategy is achieved.

(6-4B)

Maintain accreditation of MHA facilities by the Joint Commission.

**Indicator:**

- All MHA facilities accredited

**Involved Parties:** Brian Hepburn, MHA Office of the Executive Director; Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Gayle Jordan-Randolph, MHA Office of the Clinical Director; MHA Management Committee; MHA Facility CEOs; appropriate facility staff

**MHA Monitor:** Mary Sheperd, MHA Office of the Deputy Director for Facilities Management and Administrative Operations

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

All MHA facilities have maintained their Joint Commission accreditation status. The state psychiatric facilities are significant participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland.

In FY 2013, the Management of Aggressive Behavior Workgroup continued to meet to determine facility and staff needs. As one of the recommendations of this initiative, Health and Safety Management Teams were established at Springfield, Spring Grove, Eastern Shore, and Clifton T. Perkins Hospital Centers in FY 2012 and continue to operate as collaborative efforts between facility management and direct care staff. Each team has developed activities based on the data at its specific facility. This team participation has: positively impacted collaboration across disciplines; increased awareness of ward milieu; reduced staff and patient assaults; and increased opportunities for active participation of ward staff in the treatment team meetings.

**Strategy Accomplishment:**

This strategy was achieved.

(6-4C)

Increase public awareness and support for improved health and wellness through use of technology.

Indicators:

- Continuation of support and promotion of the Network of Care (NOC) ([www.maryland.networkofcare.org](http://www.maryland.networkofcare.org)); Web-based site promotion of county-specific resources for mental and behavioral health services throughout the state
- Continued efforts regarding research and distribution of information pertaining to using interactive technologies to promote services and outcomes
- Specialized service information provided for Maryland's youth, veterans, and families; improvement of existing formatting to create ease of system navigation and use
- Partnerships continued with county agencies and mental health entities; promotion and expansion of features within the NOC site.

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Anne Arundel County CSA

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

**FY 2013 activities and status as of 6/30/2013 (end-year report):**

All of Maryland's 24 jurisdictions now have access to the Maryland Network of Care (NOC) for Behavioral Health. In FY 2013, NOC recorded 2,327,670 sessions. ([www.maryland.networkofcare.org](http://www.maryland.networkofcare.org)). Information and resources in the communities and specialized service information are provided and have been updated for Maryland's youth as well as a special portal for Veterans and families to help service men and women, returning from Iraq and Afghanistan with behavioral issues, obtain access to services. The NOC veterans' portal recorded over 233,272 during the same time period. CSAs have been encouraged to support, at the county level, the expansion and promotion efforts of NOC to more widely inform the mental health community regarding availability of the Web system. The use of NOC is encouraged and fostered in the Wellness and Recovery Centers, as well as other community settings.

Plans are underway to train peer support specialists and peer educators to be able to train consumers on the use of NOC. Many consumers have received on-site training in the utilization of personal health record features and in the use of individual advance directives.

**Strategy Accomplishment:**

This strategy was achieved.

# Appendix

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## The Strategic Initiatives

The following eight Initiatives will guide SAMHSA's work from 2011 through 2014:

1. **Prevention of Substance Abuse and Mental Illness**—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.
2. **Trauma and Justice**—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.
3. **Military Families**—Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.
4. **Recovery Support**—Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.
5. **Health Reform**—Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.
6. **Health Information Technology**—Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).
7. **Data, Outcomes, and Quality**—Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.
8. **Public Awareness and Support**—Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Source: SAMHSA Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014, page 3.